Nikki P. Green, DDS
Robert W. Leedy, DDS · Susan C. Millner, DDS
Ft. Worth Cosmetic & Family Dentistry

Consent

1. I hereby authorize Dr. Nikki Green, DDS or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ____’s dental needs.
2. Upon such diagnosis, I authorize Dr. Nikki Green, DDS to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic embodies a certain risk.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

By typing your name below, your signature is submitted electronically.

Signature _________________________________ Date ________________

Witness ____

Parent or Responsible Party____

Relationship to Patient ____