GENERAL CONSENT FORM

Patient Name: _____ Date of Birth: _____

CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY

I hereby authorize and request the performance of dental services and procedures Dr. Edward C. Krupa, DMD may deem necessary for treatment while I am a patient in this office. I understand that Dr. Edward C. Krupa, DMD may designate dental assistants and registered dental hygienists to perform diagnostic, preventive, and therapeutic procedures which these professionals are certified and licensed to complete. I also authorize the administration of anesthetics or analgesics which may be deemed advisable by Dr. Edward C. Krupa, DMD.

I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since the initial examination and extent of dental pathology. Occasionally, once the treatment plan has been started, complications may arise which dictate additional procedures or treatment. Dr. Edward C. Krupa, DMD or his staff will always advise me of any changes.

Patient Signature: _____ Date: _____

If the patient is a minor, or if this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Printed name of Parent, Guardian or Personal Representative: _____

Signature of Parent, Guardian or Personal Representative: _____ Date: _____

Relationship to Patient: _____