I, the undersigned patient/guardian, hereby authorize the procedure(s) or course(s) of treatment listed below. I understand my/ my child dental condition and have discussed several treatments.

_____ **Initials**: I understand that I/my child will be receiving a dental examination from a state licensed dental practitioner, that while x-rays are taken of my teeth, I/my child will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a through and comprehensive examination**.** Pregnant women are required to have a medical release from their Medical Doctor prior to x-rays and dental treatment.

_____ **Initials**: I understand the risk inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

_____ **Initials:** I have disclosed my (or my child's) health history information, including allergies, reactions to medicines, diseases, and past procedures. I understand that withholding this information may affect the outcome of the course(s) of treatment. To the best of my knowledge, the questions on the Medical History form have been accurately answered. I understand that providing incorrect information can be dangerous to my/my child's health. It is my responsibility to inform the dental office of any changes in my/my child's medical status.

_____ **Initials:** I hereby authorize Dr. Jason Ashcroft and any of his qualified assistants or medical professionals to perform the procedure(s) or treatment(s) that I have been made aware of for myself/my child's oral health care needs. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures. I understand that antibiotics and analgesics and other medications can cause reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

_____ **Initials:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

_____ **Initials:** I understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is **not** a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is my responsibility to know my insurance plan and to obtain any required referrals and pay any deductible amount, coinsurance, or any other balance not paid by my insurance.

_____ **Initials:** I hereby authorize payment of the group dental insurance benefits directly to Pediatric Dentistry of Haslet. I hereby authorize Dr. Jason Ashcroft to release any information including the diagnosis and the records of any treatment to any third party payers and/or other health practitioners.

_____ **Initials:** This authorization and release shall remain in effect until revoked in writing.

Patients Name: _____

Signature: _____ _____ _____

Parent/Legal Guardian **Printed Name** **Date**