INFORMED CONSENT

Patient Name _____ Date _____

I authorize the performance upon _____
(myself or name of patient)

for the dental treatment as necessary at the office of Paul D. Walters, D.M.D., P.A. My treatment may include but not be limited to the following: diagnostic examinations, recall visits, dental cleanings, x-rays, administration of an anesthetic, root canal therapy, fillings, extractions, periodontal surgery, biopsy, replacement of missing teeth, or other restorative therapy.

I am aware and understand that not all of the above may be necessary and that I will be informed of such treatment.

_____
Signature of patient, parent or guardian

***Special Parental Consent for Dependents** who have their own transportation or are dropped off by a parent or guardian.

I hereby authorize the Office of Paul D. Walters, D.M.D., P.A. to provide treatment as necessary and/or use x-ray films in order to provide treatment as necessary for the dependent listed below.

_____
Name of Patient

_____
Signature of Parent or Guardian

_____
Date