ALL SMILES
ORTHODONTICS

Consent for Services

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of dental need. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph; I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Reddy to perform a complete orthodontic evaluation

It is recommended that all orthodontic patients get routine 6 month examinations and cleanings during treatment. If necessary, we will advise more frequent cleanings in order to monitor and maintain the patient's home plaque control.

I further understand that a $25 broken appointment fee will apply if I fail to give 24-hours advance notice to reschedule or do not show up for an appointment for any dependants or myself. In addition, I understand that any request for duplication of x-rays or charts is subject to a $20 service fee.

We allow a 15 minute grace period for all the appointments. If you are more than 15 minutes late to your appointment it is at the offices discretion as to whether or not you will need to reschedule your appointment.

I have read the above conditions of treatment and payment and agree to their content.

_____ _____

Patient, Parent, or Guardian Signature Date