Dr. Duga Dr. Feeney & Associates
Pediatric Dentistry

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Patient Name: ____

I, being the parent or guardian of the above minor patient, hereby do authorize and request the performance of dental services for this patient and the use of procedures Dr. Duga or Dr. Feeney may deem necessary during treatment.

I understand that Dr. Duga or Dr. Feeney and such assistants as they may designate to treat the above-mentioned patient will use diagnostic, endodontic, preventive, restorative, oral surgery, orthodontic/orthognathic, periodontal, and patient management techniques that are reasonable, necessary, and advisable.

I also authorize the administration of anesthetics or analgesics which may be deemed advisable by Dr. Duga or Dr. Feeney.

I have provided as accurate and complete a medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which this patient is allergic. I will follow any and all instructions as explained and directed to me for this patient and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions and receive answers to and responsive explanations for all questions about this patient's dental health, contemplated any alternative treatment and procedures, and the risk of potential complications of the contemplated and alternative treatments and procedures prior to signing this form.

I understand that the treatment plan to be presented, along with the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of dental pathology. Furthermore, by signing this, I agree to be responsible for full payment of all charges for dental services performed on the above-named patient, including any balances not paid by insurance provider. Accounts may be subject to a 1.5% monthly service charge on balances 60 days or more past due. Accounts may be subject to a $50 charge for missed or broken appointments.

DATE:____

SIGNED:____

RELATIONSHIP: ____

WITNESS: ____