PENNINGTON DENTAL CARE LLC

2425, PENNINGTON ROAD, SUIT # 101

PENNINGTON NJ 08534

CONSENT

The undersigned hereby authorize Pennington Dental Care to take X-ray, study models, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my for dental needs. I also authorize the Doctor to perform any and all forms of treatment, prescribe medication and therapy that may be indicted. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is contract between me and the insurance carrier and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance and Broken appointment charges $50.00 per hour without 72 hours notice.

Patient Signature_____ Date_____

Dentist Signature_____