DR. KENNETH G. HUDAK
748 ELMA STREET
AKRON OHIO 44310
330-376-0097
Fax: 330-384-2147

CONSENT TO PERFORM DENTISTRY/FINANCIAL RESPONSIBILITY

1. I, _____, hereby authorize Dr. Kenneth Hudak and staff to perform the following dental treatment or oral procedures, including the use of necessary anesthesia, radiographs (x-rays), or diagnostic aids. Please initial the following:

    _____ Preventative hygiene treatment, (prophylaxis) and the application of topical fluoride.

    _____ Application of sealants.

    _____ Treatment of damaged teeth using restorative filling material (fillings and crowns).

    _____ Replacement of missing teeth with dental prosthesis, (Bridges, partials/full dentures).

    _____ Removal (extraction) of one or more teeth.

    _____ Treatment of damaged oral tissue.

2. I will have the opportunity to ask questions regarding the treatment, risks, and that I fully understand the procedure.
3. I understand being parent or guardian that I take full responsibility for patient's payment and insurance information.
4. I understand that full payment/ co-payment/ deductible will be made the day that services are rendered, or patient will have to reschedule their appointment.

MINOR/CHILD CONSENT

I, the parent or guardian of _____

do herby request and authorize the dental staff to perform necessary dental services for my child, including x-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature of Parent or Guardian _____

Date: / /