Elizabeth Joseph, DDS, PLLC
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Authorizations and Consent for Minors

APPOINTMENTS - In order to provide each child with the individual care and attention that they deserve, we ask that you arrive on time for scheduled dental appointments. We work very hard to see each patient at their scheduled appointment time. Due to the nature of our practice, emergencies do happen. We ask for your patience if we are delayed in seeing your child due to treating another patient on an emergency basis.

We require twenty-four (24) hours notice if you must change a scheduled dental appointment. Less than 24 hours notice, or not showing for an appointment, is considered a missed appointment. Missing a scheduled appointment is counterproductive for both the patient and our office. A fee of $25.00, or more, may be assessed for each missed appointment.

PAYMENT - Payment can be made by cash, check, or credit card. If paying by cash, please bring small bills. We usually do not have change for big bills. Fees for any treatment diagnosed will be discussed with you at your initial appointment. Payment arrangements/finance options are available through our office.

INSURANCE - Pleas provide the front office staff with your insurance card so that we can contact your insurance company regarding your benefits. We will file your insurance claims and work with your insurance company concerning their portion of treatment fees. Remember, even if you have insurance coverage, you are responsible for payment of your account. Your insurance coverage is a relationship between you, the insured patient, and your insurance company. We have no influence over your coverage.

PHOTO RELEASE - I, the undersigned, do hereby relinquish any and all rights to photographs, portraits, transparencies, negatives, prints, Polaroid or other photographic reproductions captured with still, motion picture, video, digital or other cameras for use by this office.

CONSENT FOR DENTAL TREATMENT - I request and authorize Dr. Joseph and her staff to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Joseph to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or my child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Joseph and her staff will provide an environment designed to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I have reviewed the information on the Health History Form and it is accurate to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I agree to inform the office of any changes in address, phone, employment, etc. that occur during the course of treatment for my child. If the patient is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I understand that I will be responsible for any changes incurred on this child for dental treatment.

Patient Name: ____

Signature: ____

Date: ____

Relationship to Patient: _______________________________

Legal Guardian (if different): ___________________________