3905 Carman Rd. Schenectady, NY 12303
Ph: (518)-356-5635 fx: (518) 356-5675

- Consent for Treatment

1. I hereby authorize Doctor Oshins or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize Doctor Oshins to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% (18% APR) may be added to my account. I also agree to pay any legal interest on the balance due together with any collection costs and attorney fees incurred in the attempt of collection of this account.

Patient's Signature:_____Date:_____

Parent/Responsible Party's Signature_____Relationship to Patient _____.