TENNESSEE RIVER
DENTAL

Consent for Treatment

I hereby authorize the dentists and staff at Tennessee River Dental, PLLC, to take x-rays, study models, photographs or any other diagnostic aid that is deemed appropriate by the dentists to make a thorough diagnosis of my dental needs. I also authorize the dentists to perform any and all forms of treatment that may be indicated. The consent for diagnosis and treatment also applies to my minor child if s/he is the patient. I understand that any dental procedure with or without the use of anesthetic agents embodies a certain risk.

I understand that in the absence of the dentists at Tennessee River Dental, PLLC, a referral dentist will be made available to contact for an appointment. I have the choice of seeing this dentist for treatment, choosing another dentist, or waiting for an appointment with my dentist at Tennessee River Dental, PLLC.

_____ _____

Patient Signature Date

_____ _____

Guardian Signature (if patient is a minor) Date

_____ _____

Dentist Signature Date