Vernon L. Sheen, DMD, PA
Personalized Restorative and Aesthetic Dentistry
888 Bestgate Road, Suite 201
Annapolis, Maryland 21401

INFORMED CONSENT

1. I, hereby, authorize Dr. Sheen 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 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. If required, I also understand a check of my credit history may be made.

5. I agree that in the event this account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, cost, expenses and court costs incurred in the collection of this account.

6. I understand that if I cancel an appointment with less than 24 hours notice, there may be a failed appointment fee equal to ½ of the total scheduled appointment amount which I agree to pay before any further appointments may be rescheduled.

_____ Date _____
(Patient/Parent/Guardian Signature)

_____ Date _____
(Witness Signature)