With You for the Long Haul

WOODARD FAMILY DENTAL

PERMISSION TO TREAT FORM

Patient Name: _____ Date: _____

I, the undersigned, hereby authorize the dental team at Woodard Family Dental to perform the dental treatments and procedures that they deem necessary or advisable for the maintenance of my oral health.

I understand that there may be other treatment options available, and I will be given the opportunity to ask questions and receive information about the recommended treatment and alternatives. I have the right to decline treatment.

I understand that any dental procedure comes with potential risks and complications, and I assume responsibility for any potential complications or adverse reactions that may arise from the treatment.

I further understand that I am responsible for payment of all services rendered at this dental office, and that payment is due at the time of service.

I hereby authorize Woodard Family Dental to release any information necessary to process insurance claims for services provided to me.

I acknowledge that I have read and understand the above information, and that I have had the opportunity to ask questions and receive answers to my satisfaction.

Signature: _____ Date: _____

Printed Name: _____

Relationship to patient: _____