PATIENT CONSENT FORM

PATIENT NAME: X____________________DATE:X____________

1. I hereby authorize Dr Allen Shapiro & Dr. Brian Shapiro and whomever he may designate as his assistants to perform the following treatments:

Exams, X-rays, cleanings, restorative (amalgams, composites, crowns and root canals), and teeth whitening.

And if any unforeseen condition arises in the course of the treatment called on his judgment for procedures in addition to, or different from these now contemplated. I further request and authorize him to do whatever he/she deems advisable.

2. The nature and purpose of the treatment, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me.

3. I acknowledge that no guarantee or assurance has been made as results that may be obtained.

4. I consent to the administration of local anesthesia, as indicated, to be applied by or under the direction of the doctor on duty and the use of such anesthesia and analgesics as he may deem advisable.

5. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO TREATMENT AND THAT EXPLANATIONS THEREIN REFERRED TO ARE ACCEPTABLE.

6. I consent to release any information concerning my treatment to my insurance carrier and referring dentist.

X______________________________ ____________________
Signature of Patient/Guardian Witness

DR ALLEN P. SHAPIRO, D.D.S.
DR BRIAN S. SHAPIRO, D.M.D.