General Consent for Examination and Treatment

I hereby consent to having dental radiographs, clinical examination and performing treatment upon

_____ by Bethesda Dental Health.
(Patient Name)

I understand that dental radiographs are necessary diagnostic procedure to allow Dr. Larijani to make good treatment decisions. I have been given the opportunity to ask questions about the nature and purpose of the treatment, alternative treatment, benefits, risk of each and consequences of no treatment. I have the right to refuse treatment. No guarantee, warranty, or assurance has been given to me that any treatment will be successful or to my complete satisfaction. This consent pertains to treatment rendered upon said patient while in the physical office of Bethesda Dental health by Dr. larijani or her associates.

Photographs

Bethesda Dental Health may take photographs for certain procedures. These photographs are used for planning your treatment, insurance, laboratory, patient education, and advertising purposes. Photographs will not be taken without verbal consent from the patient. All photographs and/or duplications are property of Bethesda Dental Health.

Email and Text Communications

Your email address is for office use only and will not be sold to any advertising agency. Our email communication is one way communication and, therefore, will not allow for conversations between the patient, doctor or staff about treatment or treatment cost. Occasionally, we may use a third party to facilitate this communication.

Do we have your permission to communicate with you through Emails and Text

- □ Yes
- □ No

Please sign below if you agree to above and your questions have been answered to your satisfaction.

_____ _____

Signature of Patient or Legal Guardian Date