THE HOLLYWOOD PARK DENTIST

C R Feller Jr DDS MAGD FAAID
(210) 496 – 1919 Cell: (210) 722 - 2241

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aid deemed appropriate by Doctor to make a through diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate credit reports may be obtained.

Patient Signature (Parent of Child) _____ Date: _____

Dentist Signature _____ Date: _____