



6179 SOUTH BALSAM WAY SUITE 220
LITTLETON, COLORADO 80123
PHONE: 303 932-2872
FAX: 303 933-3486

CONSENT FORM

The undersigned hereby authorizes the Doctor and staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorized 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 a certain risk. The medical information supplied by me on the front side of "The Health History & Registration" form is accurate and complete to the best of my knowledge.

I will not hold my Doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

I understand that my dental insurance is a contract between the insurance carrier, and myself and not between the insurance carrier and the Doctors and that I am still fully responsible for all dental fees. I also assign all insurance benefits to the Doctors, and any payments received to my account or refunded to me if I have paid the dental fees in advance. If financial arrangements are needed and are not made before services are rendered and your account becomes delinquent within 90 days, a charge of 21 percent interest per year will apply and be turned over to a Credit Bureau. In the event an overdue balance occurs, I accept all responsibility of paying attorneys' fees. I understand that where appropriate, credit reports may be obtained.

Patient signature _____ Date _____
(Parent/Guardian of Child)

DAVID L. CREER, D.D.S. • LORIN B. CREER, D.D.S.
GENERAL, COSMETIC AND RESTORATIVE DENTISTRY