Diane Bonanni, DMD
Family and Cosmetic Dentistry

General Consent

I, the undersigned, hereby authorize the doctor to take **radiographs, study models, photographs, or any other diagnostic aids** he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to **perform any and all forms of treatment, medication, and therapy that may be indicated, including, but not limited to examinations, local anesthetic, restorative, and preventive treatment**. I authorize and consent that the doctor employs any such assistance as he/she deems appropriate.

I further authorize the **release of any information, including the diagnosis, radiographs, and records of any treatments or examinations rendered to my insurance company, consulting professionals, or others that may request my records**.

I understand that **I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage**. Breach of this responsibility carries the penalty of compensating the practice for any related attorneys and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

This general informed consent may remain in effect until treatment is terminated either by the licensee and/or the patient and the patient is no longer regarded as a patient of record.

I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue.

Date: _____

Signature of Patient: _____

Dentist: _____

Legal Guardian: _____

Relationship to Patient: _____