CONSENT

1. I hereby authorize Dr. Bob Leedy, D.D.S, Dr. Nikki Green, D.D.S. or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a through diagnosis of (name of patient) _________________'s dental needs.
2. Upon such diagnosis, I authorize Dr. Bob Leedy, D.D.S. or Dr. Nikki Green, D.D.S. to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic embodies a certain risk.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient___________________________ Date ___________

Witness____

Parent or Responsible Party____________________________ Relationship to Patient