LISA A. GOFF, DMD
FAMILY & COSMETIC DENTISTRY

2717 N. WICKHAM ROAD
MELBOURNE, FLORIDA 32935
321-242-2766

AUTHORIZATION FOR MEDICAL AND DENTAL TREATMENT

I hereby authorize and consent to any treatment or procedure or the administration of necessary anesthetics which my dentist deems advisable in the diagnosis and/or treatment of this patient. By signing this medical authorization and consent, I understand that as matter law it shall be conclusively presumed:

A. That the action of my dentist in obtaining this consent from me was in accordance with an accepted standard of medical-dental practice among members of the medical-dental profession with similar training and experience in this or similar medical communities; and from information provided to me by my dentist, I, under these circumstances, have at least a general understanding of the procedures, the medically accepted alternative procedures or treatments and the substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among dentists in this or a similar community who perform similar treatments or procedures;

OR

B. That I, considering all the surrounding circumstances, would have undergone such treatment or procedure had I been advised by my dentist as described in paragraph A above.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Lastly, as Insurance Companies have different contract years it will be my responsibility to keep track of insurance benefits used throughout the year. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18%APR) may be added to my account. I also understand and agree that Dr. Goff's office reserves the right to charge for appointments not kept or not cancelled at least 24 hours before scheduled appointment time. Your cooperation in keeping appointments will be greatly appreciated.

Patient _____ Date _____

Signature Patient/Parent or Responsible Party _____

Relationship to Patient _____

Witness _____