JOEL W. UMALI, D.D.S.
232 Cajon St. Suite C
Redlands, CA 92373

Consent for Treatment

Please read the following information and ask any questions you might have before signing the consent for treatment.

1. I hereby authorize Dr. Umali or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize Dr. Umali to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. 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.

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. 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.

_____	_____	_____
Patient Name (Please Print)	Patient Signature	Date
_____	_____	_____
Guardian or Responsible Party (Please Print)	Guardian or Responsible Party Signature	Date