COLUMBIA STREET DENTAL GROUP
876 COLUMBIA STREET
HUDSON, NY 12534

CONSENT FORM

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with

   (NAME OF PATIENT)_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

3. I understand that all responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1½ % (18% APR) may be added to my account in addition to any collection charges.

4. I understand that where appropriate, credit bureau reports may be obtained.

5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.

6. I authorize the use of my social security number to file my dental claim.

Patient_____ Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient_____

FOR OFFICE USE: Reviewed by Dr. BARRY STEINBERG_____ Date_____