DISCOVER DENTAL CENTER

Annual Patient Acknowledgement and Consent Form

Name _____ DOB_____

Consent for Treatment:

I hereby authorize Dr. Earl O'Hara/Dr. Brent Mayginnes or designated staff to take radiographs, impressions/study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Earl O'Hara/Dr. Brent Mayginnes to make a thorough diagnosis of any dental needs.

Upon such diagnosis, I authorize Dr. Earl O'Hara/Dr. Brent Mayginnes to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide care.

I agree to the use of anesthetics, sedatives, and all other medication as medically 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 at anytime.

Lastly, 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.

Missed Appointment Policy:

24 hour notice is required for all cancellation of appointments.

1st "no show" within a 1-year period appointment is an $25.00 charge
2nd "no show" within a 1 year period appointment is an $75.00 charge.
3rd "no show" within a 1-year period will be a dismissal letter from our practice.

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Patient/Guardian Signature Date

EARL M. O'HARA, D.D.S. • BRENT MAYGINNES, D.D.S.
785.825.4605
1830 South Ohio • Salina, KS 67401
www.salinadiscoverdental.com