



WELLNESS SPRINGS DENTAL

CONSENT FOR SERVICES

Wellness Springs Dental® of Salem
Stephanie Rose, DMD, Shruti Jadeja, DDS, Denise Gates, DMD & Associates

Welcome to Wellness Springs Dental® of Salem! We are excited that you have chosen our office to help you to great oral health. We appreciate the trust you have placed in us, and we will do our best to provide the high-quality dental care that you expect and deserve. We believe you should receive prompt attention and excellent service. We believe a satisfied patient returns for additional services and refers others to the office that they feel would benefit from our services.

By signing, you hereby authorize the Doctors and/or their assignees to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of your dental needs. Additionally, you give permission for such items to be used for purposes of research, education, marketing or publication in professional journals. In addition, unless you notify our office otherwise, we may use your written comments in material to promote Wellness Springs Dental® and/or the Doctors.

By signing, you hereby authorize the Doctors and/or their assignees to perform any and all forms of treatment, medication and therapy that may be indicated. By signing, you also indicate your understanding that the use of anesthetic agents embodies a certain risk.

By signing, you hereby authorize Wellness Springs Dental®, the Doctors and/or their assignees to release information to third party payers about your treatment, and to other health practitioners involved in your care.

By signing, you hereby agree to assign all insurance benefits to Wellness Springs Dental® and/or the Doctors.

By signing, you hereby grant your permission to Wellness Springs Dental® and the Doctors or their assignees to contact you at home or at work to discuss matters related to your care.

I have read and understand the above conditions and agree to their content.

Signature of Patient or Legally Authorized Representative

Date

Printed Name of Patient or Representative

Relationship to Patient

Emergency Contact: In the event of an emergency, whom should we contact?

Name

Relationship

Phone Number