Vernon L. Sheen, DMD, PA
The Annapolis Center for Dental Health & Wellness
888 Bestgate Road, Suite 201
Annapolis, Maryland 21401

# INFORMED CONSENT

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

2. **I grant Dr. Sheen permission to use the above mentioned x-rays, study models and photographs for educational and/or marketing/advertising purposes. *** Initials _____**

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

4. 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.

5. 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. If required, I also understand a check of my credit history may be made.

6. I agree that in the event this account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, cost, expenses and court costs incurred in the collection of this account.

7. I understand that if I cancel an appointment with less than 24 hours notice, there may be a failed appointment fee equal to ½ of the total scheduled appointment amount which I agree to pay before any further appointments may be rescheduled.

This contract is under seal.

_____ (SEAL) Date _____
(Patient/Parent/Guardian Signature)