RESPONSIBILITY AND CONSENT STATEMENT

SOUTH AUSTIN DENTAL ASSOCIATES
4419 FRONTIER TR. STE. 104
AUSTIN, TX. 78745
(512) 444-1133

MICHAEL L. BUTCHER, D.D.S. **JOHN D. CHELKOWSKI, D.D.S.**

Date: _____

I hereby authorize doctors Butcher or Chelkowski or designated staff to take x-rays, study models, photographs, and diagnostic aids deemed appropriate by doctors Butcher or Chelkowski to make a thorough diagnosis of my dental needs.

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

I give my consent to any advisable and necessary dental procedures, such as, Root Canal therapy & extractions. Some very infrequent complications are possible to the tooth or root, such as, damage to existing restorations, fractured root, file breakage and possibility of pain, swelling and infection.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks, such as, loss of sensation to an area which may be temporary or permanent in duration.
I understand I can ask for a complete explanation of any possible complications.

I understand and acknowledge that I am financially responsible for the services provided on my behalf or my dependants, regardless of insurance coverage.

Patient's Signature _____ Date _____

Parent/Responsible Party Signature _____

Relationship to Patient _____