Direct Mobile Dentistry

2480 Windy Hill Rd. S.E Suite 202

Marietta, Ga. 30067

I, ________________________________ consent for myself or my family member ________________________________to be a patient of Direct Mobile Dentistry and agree to treatment which may include one or more of the following: x-rays, clinical exam and /or cleaning.

I also understand and consent to the following:

1- I will consent to the dentist communicating with my or my family member's other medical practitioners to inquire about any aspect of my or my family member's health history.

2- No guaranties can be made about treatment outcomes, restoration longevity , or prognosis. I understand that any branch of medicine, including dentistry , can involve unanticipated results.

3-I will pay in full any cost of treatment according to the financial policy of this business. Payment is required either at time of service or within one statement period(30 days) if previously agreed upon.

4- My or my family member's treatment plan may change at any time and I will do my best to approach my or my family member's dental care with optimism and open communication with the dentist, hygienist, assistant , and dental office staff.

5- I am welcome to ask any questions about any aspects of my or my family member's care and will request information if I am confused or need more information , such as costs of services and insurance participation by this business.

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Patient or Guardian(POA) Signature Date