CONSENT FOR TREATMENT

PATIENT'S NAME _____ DATE _____

I hereby authorize Dr. Raul Mosqueda D.D.S. & Associates to perform upon me or the patient named above recommended treatments deemed necessary after my initial examination. I understand that during the course of the treatments unforeseen conditions may arise which necessitate treatments different from those contemplated. I, therefore, will be given the opportunity to consent or reject the performance of additional treatments, which the above named dentist or his associates may consider necessary. I also understand that no treatment is completely risk free. I understand that some after-treatment effects and complications can occur. These include; allergic reactions, pain, swelling, bruising, bleeding, infections and prolonged numbness. I acknowledge that no guarantees have been made to me concerning the results intended from the treatments.

I also understand the financial obligation attached to this agreement and consent. I understand that I am responsible for all the fees regardless of insurance coverage. I also understand that as treatment progresses the above fees may have to be adjusted, but that I will be informed of these adjustments and how they will affect my payment plan. In the event that my payments are not received within thirty (30) days of this due date, I agree to pay all costs of collections, including, but not limited to, reasonable attorney's fee.

I confirm that I have read and fully understand the above prior to my signing. I hereby consent to the proposed treatments.

_____ _____

Signature of Patient, Guardian or Parent if minor Date

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives (including no treatment and attendant risks), to the proposed treatments.

_____ _____

Signature of Dentist Date
Raul Mosqueda, D.D.S.

TEXT & EMAIL NOTIFICATIONS CONSENT

___ I DO wish to receive Text Message reminders cell number _____

___ I do NOT wish to receive Text Message reminders

___ I DO wish to receive E-Mail notifications email _____

___ I do NOT wish to receive E-Mail notifications

Patient Signature _____ Date _____