STEPHEN R. JACAPRARO, D.M.D.
FAMILY DENTAL CARE

1379 MAIN STREET
AGAWAM, MASSACHUSETTS 01001
TELEPHONE (413) 786-8177

General Consent Form for Treatment

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of Dental Services provided in this office for myself or my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balances. I also assign all insurance benefits to the Doctor.

Patient Name:________________________________

Signature
x:______________________________**Date:**____________________________