CONSENT TO TREAT

The undersigned hereby authorizes Fabre Family Dental Care and Staff 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 need. I also authorize the Doctor to perform any and all treatment, medication, and therapy that may be indicated. I understand the use of anesthetic agents embodies a certain risk. I certify to the above information to be true and I understand that I am responsible for payment for all treatment and services rendered

_____ _____

Patient's Signature Date

_____ _____

Parent/Guardian Signature Date