Burleson ENDODONTICS

Consultation Consent

Date: _____

I _____ give Dr. Alex Fitzhugh permission to perform an exam and take diagnostic radiographs to determine treatment. I also give permission to discuss treatment, clinical notes and radiographs with my previous dentist or any other dentist/specialist. I understand that if the consultation is not a covered by my dental insurance that I am responsible for any out of pocket expense. If you have any questions, please discuss with our office

Sincerely,

Burleson Endodontics

Patient/Parent Signature: _____. Dentist Signature:_____