FAMILY DENTISTS
KARL BREUCKMANN, DDS
www.OlatheFamilyDentists.com
OLATHE 913-782-6533

I, _____, hereby give **Karl A. Breuckmann DDS, PA** the absolute right and permission to use my photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.

Signature_____ Date_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my or my dependents dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1½% late charge (18%APR) may be added to my account. If required, I also understand a check of my credit history may be made.
5. I understand that a 10% deposit will be required on all major treatment to reserve an appointment with the Doctor.
6. I understand that 48 hours' notice is required for schedule changes and that a fee/or loss of deposit may apply should notice not be received.

Patient's
Signature_____Date_____

Parents/Responsible Party's Signature_____

Relationship to the Patient_____Date_____

Witness_____Date_____