GILCHRIST DENTAL CARE

ADMISSION TO THE PRACTICE AGREEMENT

I consent to routine dental procedures as well as treatment and diagnostic tests deemed necessary in the dental professional's judgment.

I authorize the dentist and staff of Gilchrist Dental Care to take and record any photographs of me for records, teaching, research and publication purposes. I understand that if my photos are utilized in any way my identity will remain confidential.

I authorize Gilchrist Dental Care to take any x-rays necessary for the detection and diagnosis of oral diseases, and I authorize the release of this and any other information to my insurance company necessary for the processing of my dental claim (if applicable).

I authorize Gilchrist Dental Care to administer local anesthetics and medically indicated drugs as necessary for treatment.

_____ _____

Signature (Patient or Legal Guardian) Date