TROPICAL SMILES
Kendall R. Schumacher, DMD Family Dentistry

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed-upon dates, I understand that a 1-1/2% finance charge (18%APR) may be added to my account.
4. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient:_____Date:_____Witness:_____

Parent or Responsible Party:_____Relationship to Patient:_____

CONSENT TO USE OR DISCLOSE DENTAL AND MEDICAL INFORMATION

I authorize Kendall R. Schumacher, D.M.D., PLLC to use and disclose the dental, medical and health information of

_____for the following purpose(s)
(Name of Patient)

- Treatment- Includes activities performed by a dentist or dental hygienist, as well as coordinating or managing care provided to you with third parties, and consultations involving dentists, physicians, and other health care providers.
- Payment- Includes activities involved in determining whether you are eligible for dental plan coverage, billing matters, and reimbursement for your dental benefit claims, as well as utilization management programs addressing review of dental services for clinical necessity, appropriateness of charges, precertification and preauthorization of services.
- Health Care Operation- Includes associated business and administrative affairs of this office.
- Other (explain):
  _____
  _____

You have the right to revoke this Consent. However, you must revoke this consent in writing. Any revocation would not pertain to information already used or disclosed pursuant to this Consent during the time frame within this Consent is effective.

_____ _____
Date Signature of Patient

_____ _____
Date Signature of guardian or other person authorized by law