Periodontal Associates
PERIODONTICS | DENTAL IMPLANTS | BONE REGENERATION

Cary N. Feuerman, DMD
Giovanni Castellucci, DMD

GENERAL INFORMED CONSENT

I _____ hereby authorize Dr. Feuerman/Dr. Castellucci, and whomever they may designate as their assistant(s), to perform the following:

- General periodontal/ dental examination
- Diagnostic X-rays if necessary
- Diagnostic tests deemed appropriate for proper diagnosis and evaluation
- Emergency treatment of a specific situation (e.g. abscess) as deemed necessary at the time of the examination
- Diagnostic photographs (for educational and scientific purposes only)
- General periodontal maintenance and cleaning
- Submit necessary forms to my third party dental insurance

_____
Responsible Party Print Name

_____Date_____
Responsible Party Signature

_____
Witness Print Name

_____Date_____
Witness Signature

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