



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

Responsible Party Signature

Date _____

Witness Print Name

Witness Signature

Date _____