LOUISIANA ORAL & IMPLANT SURGERY

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Consent for General Medical Treatment

I authorize Dr. Maskas and his designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning.

Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

I permit messages to be left on my phone and / or mobile phone concerning my appointment.

_____ _____

Patient/Parent/Guardian – Printed name Date

_____ _____

Patient/Parent/Guardian – Signature Date