Michael B. Jones
20406 Brian Way, Ste. 2
Tehachapi, CA 93561
(661) 822-6706

CONSENT

I consent to all necessary treatment for the care of the patient signed below, including but not restricted to whatever drugs, medicine, performance of operations, laboratory, x-ray and other studies used by the attending dentist or qualified designate.

I have provided insurance information to the office with the understanding that my insurance will be billed as a courtesy to me. Should the insurance fail to pay, I realize I am fully responsible for charges incurred. I also realize that the office is not responsible for estimated benefits.

If no insurance is indicated, I accept full responsibility for the payment of such services and agree to pay them in full, at the time of service, unless other arrangements are made in advance.

Sign:____

Patient, Parent, or Agent (must be at least 18 years of age)