GENE C. MEARS D.D.S.

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Office of Dr. Gene C. Mears

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Gene C. Mears and Staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize Dr. Gene Mears to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

_____	_____	_____
Patient Name	Patient or Responsible Party Signature	Date