



Dr. Mamak Saffarpour, DDS

3535 Ross Ave, Suite 200

San Jose, CA 95124

408-269-2944

Patient Name: _____

DENTAL TREATMENT CONSENT FORM

I hereby authorize Dr. Mamak Saffarpour to take any X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by said doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Saffarpour to perform any and all recommended forms of treatment mutually agreed upon by myself and the doctor. I consent to the use of the appropriate medications, anesthetics and therapy that may be indicated in connection with myself or the above named patient. I understand that there may be a certain risk when using these anesthetic agents. Furthermore, I authorize and consent that Dr. Saffarpour choose and employ such assistance as deemed fit to provide the recommended treatment.

X

Responsible Party Signature

Date

Relationship

FINANCIAL POLICY

I understand that responsibility for payment for dental services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered unless financial arrangements have previously been approved. If, for any reason, I do not have coverage under my dental plan or my dental plan covers only a portion of the fee, I understand that I am personally responsible for the value of the services received. I further understand that any balance I owe which exceeds 30 days will be charged a finance charge at the rate of 21%. In the event of default of payment, I agree to be responsible for all attorney's fees and other court costs. Returned checks may be subject to \$25.00 collection fees plus banks fee's

X

Responsible Party Signature

Date

Relationship

APPOINTMENT AGREEMENT

Missed Appointments: Our doctor and staff designate a specific amount of time to each patient. Please call 24 hours in advance on the weekdays and 48 hours in advance for Saturdays to reschedule or cancel your appointment. A \$50.00 charge for weekday and \$70.00 per hour for Saturdays will be incurred if we do not hear from you before the designated time.

X

Responsible Party Signature

Date

Relationship

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Members of the American Dental Association and California Dental Association.

We take your smile to heart!