Angela P. Moss, D.D.S,
4000 Mitchelville Road Suite 330B
Bowie, MD 20716

Consent Agreement

1. I hereby authorize the doctor or designated staff to take xrays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

2. If further information is needed you have my permission to ask the respective health care provider or agency, who may release such information to you.

3. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

4. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

5. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize the doctor to obtain a financial credit report. I understand that payment is due at time of service unless other arrangements have been made.

Patient or Legal Guardian Name | Relationship to Patient

Patient or Legal Guardian Name Signature | Date

AUTHORIZATION FOR RELEASE OF DENTAL INFORMATION

I, _____ authorize, Angela P. Moss, D.D.S. and staff, to disclose my dental information with the following person(s).

Name: _____ **Relationship:** _____

_____ _____

_____ _____

Patient Signature: _____ **Date:** _____