Colwood Dental Group

Patient Name:

I the undersigned understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted any data. I consent to the release of medical information from my medical doctor, or other health care provider, as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I consent to this office treating my oral health needs based on the findings of these diagnostic procedures.

All of us here look forward to serving you and taking care of your oral health needs, and welcome you and your family to our team of dental professionals.

I have read the above policies of this office and understand my responsibilities as a patient.

_____ _____

Date Signature of Patient or Parent Guardian