CHAPMAN ORTHODONTICS

ORTHODONTICS OF CENTRAL INDIANA, PC DBA DR. PETER CHAPMAN ORTHODONTICS

Consent for Orthodontic Pre-treatment Exam and Disclosure of Policy Regarding Preparation of Pre-Treatment Records

Patient Name _____

I have been informed that a pre-treatment exam and preparation of pre-treatment records are necessary before an orthodontist can make any specific treatment recommendations for my care. Pre-treatment records include a panoramic x-ray, and facial and intra-oral digital photographs. I hereby consent to this complete orthodontic examination and to the taking of any necessary pre-treatment records.

I understand that undergoing the pre-treatment exam and the making of pre-treatment records does not create a contract or guarantee that Central Indiana Orthodontics, Inc., Orthodontics of Central Indiana, P.C. their agents and employees, will provide me with orthodontic treatment. I have been informed that if, after discussion, I choose to go forward with orthodontic treatment, a separate consent will need to be signed.

I understand that there is no cost for the pre-treatment exam, photos, or panoramic x-ray.

By signing this document, for treatment planning purposes, I hereby authorize Central Indiana Orthodontics, Inc., Orthodontics of Central Indiana, P.C. and their agents to obtain and share healthcare information, verbally or through written materials, with other healthcare providers. This can include the patient's dentist, physician, other healthcare providers, and/or any insurance providers and can include any information related to the treatment and care of the patient during their orthodontic treatment. This will include a consent for any pre-treatment needs from another provider prior to beginning orthodontic treatment.

I certify that I have read and understand the above information. In addition, I certify that, if I am signing on behalf of a minor, I am a parent or guardian of the patient with the legal right to consent for his/her dental care.

_____	_____	_____
Patient, Parent, or Guardian	Relationship to Patient, if applicable	Date
_____	_____	_____
Patient, Parent, or Guardian	Relationship to Patient, if applicable	Date

Witness:_____ _____

Date