Jennifer A. Neise, DDS, PC
Kevin J. DeaKyne, DDS, PC

3132 W SR 38 Pendleton, IN 46064
Ph. (765)778-7585

Authorization of Treatment:

I hereby authorize and consent the treating dentist and other personnel at the office of Jennifer A. Neise, D.D.S., P.C. to perform the operations, procedures, techniques, and clinical photographs that the dentist in attendance deems necessary for my care.

I understand this consent will remain in force until I revoke it in writing. I understand that during the course of treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make any/all changes and additions as necessary.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to ask questions. My questions have been answered to my satisfaction. I consent to the purposed treatment.

I authorize the office to leave an email, voice or text message about upcoming appointments or diagnosis of treatment, to the address or phone numbers I have provided.

I authorize:

_____ (name) _____ (relationship) _____ (phone #) to phone on my behalf.

_____ (name) _____ (relationship) _____ (phone #) to discuss treatment, diagnosis, and/or finances.

_____ (name) _____ (relationship) _____ (phone #) to make decisions for my dependent.

_____ SIGNATURE _____ DATE