



The office of Dr. Scott Thomas  
 www.ShoalCreekSmiles.com  
 (816) 781-5437

**Consent From**

I hereby authorize, for the patient named below, examination and treatment by members and employees of Shoal Creek Pediatric Dentistry, LLC and any assistants or designees deemed necessary by Dr. Thomas. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations in this office.

**Release of Information**

I authorize the release of information concerning this office visit to the primary care physician, family physician, referring physician or dentist.

**Photographs**

I authorize the taking of a digital photograph of my child for this/her dental file.

**Assignment of Benefits and Guarantee of Payment**

I hereby authorize payment of third-party benefits, otherwise payable to me directly to Shoal Creek Pediatric Dentistry, LLC not to exceed this offices regular charges. I understand that I am financially responsible to the hospital and/or Shoal Creek Pediatric Dentistry, LLC for the above named patient and I agree to pay Shoal Creek Pediatric Dentistry, LLC all amounts incurred by the below named patient not covered by a third party payer within 30 days as bills are presented if arrangements have not been made with this office.

Patients Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patients Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Interpreter Consent**

I read the above statement to \_\_\_\_\_ at \_\_\_\_\_ : \_\_\_\_\_ (  AM /  PM )

He / she stated understanding and approval.

\_\_\_\_\_  
 Interpreter's Signature

\_\_\_\_\_  
 Printed Name

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_