

**3720 NW 43rd St, Suite 102**

**Gainesville, FL 32606**

**Ada Parra, DDS, MS**

**Justin Craighead, DMD, MS**

**CONSENT AND AUTHORIZATION DENTAL AND/OR MEDICAL SERVICES**

We appreciate the opportunity to serve you. It is our intent to provide you the finest care possible while insuring that you full understand our procedures and treatment. To insure that your care comes first, we require your consent for Premier Dental Team to treat you under all circumstances while in this facility as follows:

The undersigned, on behalf of himself/herself, or minor (if applicable) hereby authorizes and consents to any x-ray examination, anesthetic, medical or surgical diagnosis, treatment and/or transport to hospital care (if deemed necessary) to be rendered by Premier Dental Team, licensed dentists in the State of Florida.

I HEREBY CONFIRM, CONSENT, AND AGREE TO THE FOREGOING

Signature of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

**IF THE PATIENT IS A MINOR, A SIGNATURE OF THE PARENT OR GUARDIAN IS REQUIRED.**

Signature of guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

(Parent, guardian, or person having legal custody of patient if minor)