Dr. Mary Ellen Hoye D.D.S.
Dr. Debra Alavi, D.D.S., M.S.
15927 South Bell Road, Homer Glen, IL 60491
708-301-3444
815-838-5500

Date: _____

Patient's Name: _____

Parent's Name If Different From Above: _____

I hereby authorize Dr. Hoye (Dr. Alavi) to perform upon me or the named patient the following procedure(s):
Please Circle:

Y	N	Prophylaxis
Y	N	X-Rays (as needed)
Y	N	Fluoride treatment
Y	N	Fillings- Composite/Amalgam where appropriate
Y	N	Fillings- Composite only
Y	N	Fillings- Amalgams only
Y	N	Crowns or caps
Y	N	Root canal treatment, including the necessary restorative (post & crown)
Y	N	The use of anesthetic for the procedure.

Other: _____

_____

_____

Dr. _____ has explained to me the purpose of the procedure(s), and has also informed me of expected benefits and complications (from known and unknown causes). Attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and I, therefore, consent to the performance of additional procedure(s) which the above named dentist or her associates may consider necessary.

I understand that I am responsible for all fees regardless of insurance. I also understand that as treatment progresses the fees may have to be adjusted, but that I will be informed of these adjustments and know how they will effect my payments. In the event that my payments are not received within 30 days of their due date, I agree to pay all costs of collections, including but not limited to, reasonable attorney's fees.

I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing.

I hereby consent to the proposed dental treatment.

_____ _____
Signature of patient or parent if minor Date

_____ _____
Signature of witness Date

Dentist Certification
I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives (including no treatment and attendant risks) to the procedure(s). I have offered answers to any questions and have fully answered all such questions. I believe that the patient/parent/guardian fully understands what I have explained and answered.

_____ _____
Dentist's signature Date