CONSENT

The undersigned hereby authorizes the doctor to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patients dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (name of patient) ____
and further authorize and consent that the doctor choose and employ such assistance as he deems fit. I understand that the use of anesthetic agents and certain treatments embody some risk. In good faith, the doctor will present these risks and alternatives to proposed treatment and my questions will have been answered in order to proceed in an informed fashion.
I hereby give my permission to Smiles on State Street to release my dental records to my insurance company, specialist I may be referred to, or others to whom I may request my records to be sent. I understand I have the right to review Smiles on State Street Privacy Notice.

____ ________________________
Signature of Patient, Parent or Guardian Date

LIFETIME PROFESSIONAL WHITENING

Promotion Includes:

* 1 set of Professional Whitening trays with 2 tubes of professional strength whitening gel.
* 1 tube of whitening gel at each 6 month cleaning appointment.

Offer Good While:

* Dr. Mortensen is your current dentist.
* Regular 6 month cleaning appointments are kept.
* Account with Smiles on State Street is in good standing.

____ ________________________
Signature Date