Family Smile Center, LLC
5950 Frederick Crossing Lane, Suite 201
Frederick, MD 21704
301-663-9484

WAIVER FOR THE EXAM AND XRAYS

I, ________________________________, wish only to have treatment rendered to tooth number___ at the office of Family Smile Center, LLC. At this time I do not wish to have an examination and/or x-rays taken, although this is highly recommended for a comprehensive dental visit. I understand that I may have extensive dental disease which could become more serious over time. Furthermore, the responsibility for any other dental problems rest solely upon me, not Family Smile Center, LLC nor its staff.

Signature:____________________________________Date:_______________________

Witness:_____________________________________Date:_______________________