Lakefront Dental
111 North Wabash, Suite 1522
Chicago, IL 60602

Limited Services Consent

I, _______________________ hereby acknowledge that the evaluation exam, radiographs, diagnosis and treatment provided by Lakefront Dental will be limited to that outlined below, at my request. I further understand that this does not include a comprehensive diagnosis or treatment plan, as I have requested that my diagnosis and treatment be limited to the items set forth below.

1. ____
2. ____
3. ____
4. ____

Patient's Printed Name: ___________________________________

Patient's Date of Birth: ____________________________________

Patient's/Guardian's Signature:______________________________

Relationship to Patient: ____________________________________

Today's Date: ____