



Richard A. Murdoch D.D.S.

Smiles are our specialty

CONSENT TO TREAT ~ TELEDENTISTRY CONSULTATION

I am acknowledging that I wish to receive a tele-dentistry consultation with Dr. Richard Murdoch.

In the absence of radiographs (x-rays), I understand that I may be asked to send photographs or other documentation as requested by Dr. Murdoch. I will try to provide as much detailed information as I can. I understand that Dr. Murdoch is limited to what he is able to determine in these circumstances.

I also understand that if I am experiencing pain or swelling that is life threatening, I will call 911 or go to an emergency room.

I understand that I am responsible for any payment resulting from this consultation that is not covered by a dental insurance plan. In addition, I understand and consent to this consultation being recorded for clinical documentation and accuracy.

Date: _____

Patient Name (please print): _____

Signature: _____

