Randy S. Weiner, DMD
10 Pleasant Street
Millis, MA 02054

I, the undersigned, hereby authorize Dr. Randy Weiner and/or his associates to take radiographs (x-rays), study models, photographs or any other diagnostic aids deemed appropriate by Dr. Weiner to make a thorough diagnosis of my (the patient's) dental needs.

I also authorize Dr. Weiner to perform any and all forms of treatment, medication, and therapy that may be indicated.

I understand that the responsibility for payment for dental services provided by this office for myself or my dependants is mine, due and payable at the time services are rendered unless financial arrangements have been made.

I assign all insurance benefits to Dr. Weiner.

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Patient signature (Legal guardian of child)

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Date