

# ORTHODONTIC SPECIALISTS

Professional Corporation

I agree to have orthodontic records taken on my child, or

myself \_\_\_\_\_

Which consists of photos, cephalometrical x-ray and a set of study models. If a panoramic x-ray is not supplied by the dentist, there may be an additional charge. Should I decide not to continue with treatment I will be responsible for the \$350.00 records fee.

Name \_\_\_\_\_

Date \_\_\_\_\_