WEBB Orthodontics

Sami J Webb D.D.S, M.S.

Date: _____

Patient: _____

This is to certify that I, as the patient/parent/legal guardian, request the removal of orthodontic appliances and the termination of treatment for _____.

I have been informed that treatment has not been completed and that Dr. Sami Webb has recommended the continuation of treatment in order to obtain the best results.

I hereby release Dr. Sami Webb from any responsibility for all consequences caused by my terminating treatment against the advice of the orthodontist.

_____ _____
Patient/Parent/Legal Guardian Date

_____ _____
Witness Date

If you are consenting on behalf of another:

I have the legal authority to sign this on behalf of _____

Relationship to Patient: _____

Signature: _____

Witness: _____