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GENERAL DENTISTRY INFORMED CONSENT

PATIENT NAME: _____

WORK TO BE DONE

I understand that I am having the following work done: Exam, cleaning, x-rays

(____) initials

DRUGS AND MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.

(____) initials

CHANGES IN TREATMENT PLANS

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. These changes could result in an increase in fees. I give my permission to the Dentist to make any/all changes and additions as necessary.

(____) initials

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

(____) initials

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized. I am not under the treatment of any other dentist outside of this practice.

(____) initials

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay 40 to 50% above principal for any cost of collections that may be incurred to satisfy this obligation.

(____) initials

Signature of Patient _____ Date _____

Signature of Doctor _____ Date _____