GENERAL CONSENT

Patient Name:_____ Date of Birth:_____

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

- I hereby authorize and direct the dentist and/or dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

- I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors but copies of certain aids are available upon request for a fee. I hereby authorize my dentist and his/her staff to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines). I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

- In general terms, the dental procedures can include but not limited to:

I. Comprehensive oral examination, radiographs, cleaning of the teeth, and topical fluoride application.

II. Treatment of diseased, or injured teeth with dental restorations (fillings).

III. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or infections.

- I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.

- I have answered all the questions about me or my dependent's medical history and present health conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s). I will inform the doctor at the next appointment.

- 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 (severe allergic reaction).

- 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.

- I certify that if I, and/or my dependents have insurance coverage I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I understand that dentistry is not an exact science, and therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

In addition, my dentist or their staff has given me a more detailed explanation of these treatments and procedures — if I so desired. I am fully satisfied with the description and information given, and all my questions and concerns have been satisfactorily answered. I acknowledge that no guarantee or warranty has been made to me about the results of any of the above choices. Therefore, I freely give my informed consent to the above treatments and procedures, should they be recommended. I further understand that this consent shall remain in effect until terminated by me.

Patient Signature:_____ Date:_____