General Consent for Treatment

Medical History Information:
It is important that you divulge all information about your medical history and that you include any medications that you are taking each time you come to an appointment as some medicines can cause adverse reactions with dental treatments, anesthetics, analgesics, antibiotics, or other medications. Please provide a list of any allergies that you have as well.

Changes in Treatment Plan:
I understand that during treatment it may be necessary to change or add procedures due to conditions found while working that were not discovered during an exam. I give my dentist permission to make changes and additions as necessary after consulting with me.

Radiographs and Photos:
Modern dental radiograph(x-rays) equipment emits extremely low-dose radiation. Diagnostic radiographs provide the Doctor with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our practice recommends routine x-rays to allow us to do a thorough exam and diagnosis for each patient. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw. We may also take intra-oral photos with a digital camera to document and monitor any conditions.

Emergency/Urgent Examinations:
If you the patient requests an appointment to address a specific area, this is considered a problem focused evaluation. A dental radiograph will be taken in this specific area only and an exam focused on this specific area will be performed. The dentist cannot diagnose other problems in the mouth as this appointment is made to evaluate and potentially treat a specific emergency or urgent need. Any future treatment of other areas will require additional x-rays and a complete comprehensive exam.

Treatment to be Provided:
I understand that the following care may include but is not limited to-
Preventive Services (Cleanings, Radiographs, Periodontal treatment, Fluoride Treatments)
Restorative work (Fillings, Crown and Bridge, Dentures)

* I understand and consent to the information provided above. I understand that at any point I may consult with my dentist with any questions or changes regarding treatment.

* I give permission to the practice to bill my dental insurance provider for the treatment provided, if applicable.

* I understand that I must provide accurate medical information to my dentist.

* I understand that this form is applicable for one year and I consent to all the items listed above.

Patient Name: _____ D.O.B: _____

_____ Date: _____

Patient/Guardian Signature