Informed Consent for Dental Treatment

Please read and initial the following. If you have any questions, please ask your doctor prior to initialing

1. Preliminary Consent for Treatment

I understand I am having any or all of the following done today: Exam, Radiographs "X-rays" and cleaning "Prophylaxis"

Initials ________.

2. Medications, Substances, and Medical Conditions

I understand that antibiotics, analgesics, "Pain medicines", anesthetics, latex and other substances can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, vomiting and/or more severe allergic reactions. I have informed the dentist of any known allergies and/or medical conditions, including possible pregnancy

Initials ________.

3. Changes to Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found during treatment that were not evident during the initial examination. Some of these changes are, but are not limited to, root canal therapy that is necessary following the placement of "deep fillings" or Crowns recommended after placement of "large fillings". I authorize my dentist to make any changes and/or additions to my treatment plan as necessary

Initials ________.

4. Dental Benefits

I understand that treatment that my dentist recommends is based on what he/she determines is best for my dental health, and not necessarily based on what an insurance plan will pay. Therefore I understand that my insurance (if any) may not cover all aspects of my treatment plan and I will be financially responsible for any treatment not covered by the insurance plan. I understand the treatment plan proposed to me is an estimate of insurance benefits and my actual coverage may differ due to frequency limitations, group coverage, incomplete information provided by my insurance company, etc. I also acknowledge that I am responsible for any balance remaining in the event that my insurance coverage is terminated for any reason.

Initials ________.

I understand dental treatment has potential risks and consequences. Likewise, so does the refusal or denial of dental treatment. Untreated conditions may lead to pain, swelling, infection, tooth loss and/or other severe consequences. I understand that dentistry is not an exact science and that no exact results can be assured or guaranteed. I have had the opportunity to have all of my questions answered by my dentist.

____. ________________________________.

Signature of Patient, Parent, Legal Guardian or Personal Representative   Date

____. ________________________________.

Please print name of Patient, Parent, Legal Guardian or Personal representative   Relationship to Patient