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CONSENT FOR TREATMENT

We are here to provide dental service to you in the most beneficial way possible. This requires mutual understanding. In order to educate and inform you, we would like you to read this consent for treatment. Your cooperation in reading and understanding this consent for treatment will aid in our mutual goals. We will attempt to make your dental experience a painless one.

I realize that unless I provide the doctor with an accurate and complete medical and dental history, that complications may result. I am aware that the dentist may need to confer with my physician, or take my blood pressure. I agree to provide all information.

I understand that certain parts of my treatment may be performed by licensed, supervised paraprofessionals other than the dentist. I thus consent to treatment by those paraprofessionals.

I understand that x-rays, photographs or models of my mouth may be necessary for an accurate diagnosis and treatment. I understand that these are the property of the doctor, but copies are available on request. I consent to the use of these diagnostic tests unless I so state prior to the implementation.

I recognize that in cleaning teeth, the dentist or paraprofessional may use a modern and efficient method known as ultrasonic cleaning. I understand that other electronic and mechanical devices will also be used in my treatment. I consent to such procedures, unless I timely object to the use of such equipment. I am aware that pacemakers are sensitive to some of this equipment, and I will immediately inform all personnel if I have a pacemaker.

I realize that in the course of treatment, drugs and medications may be used. I realize that any risks concerned with drugs will be explained to me and that, if I have questions, I will ask. I know that occasionally a reaction may occur to these drugs or local anesthetics. I understand that some risks may be involved and that if I have any questions concerning their use, I should discuss this with the doctor. I realize that, if I am experiencing any adverse reactions to drugs, medications, or treatment, I should immediately advise the doctors or their assistants.

I realize that, in the course of treatment, doctors and staff will strive to be gentle and painless. I understand that the doctor is not responsible for previously placed dental appliances or previous dental treatment. I understand that, in the course of treatment, these previously made dental applications or other existing dentistry may need adjustment. I understand that, after treatment, there may be some soreness or discomfort.

I know that I should listen carefully when the dentist advises me of any change in the plan of treatment, which may result in adjustments of treatment, change in fee, or time involved. I realize the importance of following the doctor's instructions. I realize that alternative treatment plans will be discussed with me prior to my acceptance of treatment.

I agree that fees are payable when service is rendered unless specific financial arrangements are made prior to dental treatment. Arrangements are made with the office manager. Any unpaid balance past 60 days will be subject to a service charge of 1.5% per month. I understand that the office will remind me periodically of the need for regular dental check-ups, in the interest of my dental health. I realize that guarantees of results or absolute satisfaction are not possible in dental health service. I realize that personal articles brought into the office are my responsibility. I understand that I have come here for treatment solely by my own choice.

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, 'upon receipt of full (or partial) payment of bill.' We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

I have read and understand the contents of this consent for treatment, and agree to the provisions of it. If I have questions, I will ask the doctor.

Date: _____ Signature: _____

Signature: (For Minor) _____

Relationship: _____

Thank you. Your cooperation, consent for treatment and open communication will greatly add to your dental success, and it will make looking forward toward our mutual goals much easier.

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