GENERAL CONSENT

I authorize the dentist, the practice and qualified staff to …

- Perform diagnostic procedures for the purpose of determining my oral health and treatment options.
- Perform basic clinical treatments required to restore, maintain or improve my oral health after consultation with me.
- Consult with my medical doctor or other health care professional regarding my general or oral health conditions.
- Transfer my records to another dentist if necessary or requested
- Exchange information with my insurance provider for the purpose of administering claims
- Provide major clinical treatment to restore, maintain or improve my oral health after consultation with me or clearly explain my treatment options, prognosis and risk and only after I have explicitly agreed to proceed the treatment.
- Take appropriate and advisable steps in the event of unforeseen conditions, reactions or emergencies that may arise during treatment.

I understand that …

- Basic and diagnostic procedures include (but are not limited to):
  - Periodic check-ups which re-examine the whole mouth.
  - Any treatment or service which is normally provided by a registered dental hygienist or preventive dental assistant.
  - The application of substances and techniques known to be helpful in the prevention of cavities.
  - The application of substances or techniques known to be helpful in the minimizing pain and discomfort, such as anesthesia, or de-sensitization.
  - Radiographs (x-rays) as required for accurate diagnosis or treatment planning after consultation with me.
  - Occlusal (bite) adjustment and fabrication of oral appliances.
  - The preparation of teeth and the placement of filling to restore function and aesthetics.
  - Procedures that preserve and maintain the function and aesthetics of previous restorations.
- All dental procedures have potential complications and risks that cannot always be predicted.
- I have the right to ask questions and receive complete answers regarding any procedure
- I have the right to decline or stop treatment at any time
- My choice to decline or stop treatment may adversely affect my dental health condition
- I am financially responsible for all fees incurred during the course of my treatment

Name _____ Patient ☐

Signature_____ Parent ☐

Date_____ Guardian ☐