Dental Informed Consent Statement

A healthy, beautiful smile is our goal. However, in dealing with human beings, there are intra-operative and post-operative events that may occur from the dental procedure. These events can include pain and swelling, infection; bleeding, and/or bruising; numbness of the lip; changes in the bite (occlusion); pain in the mandibular joints; injury to adjacent teeth or restorations in other teeth; injury to other tissues; referred pain to the ear, neck, and head.

I hereby authorize the dentist or designated staff to perform diagnostic procedures and treatment mutually agreed upon by me as may be required for proper dental care.

I voluntarily assume any or all possible risks that may be associated with any of these procedures. I understand it is my responsibility to diligently follow the instructions given to me in regard to my treatment.

I authorize release of any information including the diagnosis and the records of any treatment or examination rendered to me (or my child) during the period of such dental care to third party payers and/or another dentist.

I understand that I am financially responsible for services rendered regardless of insurance coverage. I also understand that as treatment progresses the fees may have to be adjusted, but that I will be informed of these adjustments. In the event that payment is not received within 30 days of the initial billing date, I agree to pay all coasts of collections, including, but not limited to, reasonable attorney’s fees.

I have provided as accurate and complete a medical and personal history as possible, including medical history and conditions, antibiotics, drugs or other medications I am currently taking as well as those which I am allergic. I will follow any and all treatment and post treatment instructions as explained and directed to me.

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Patient or Guardian Signature Date