Consent for Treatment

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I further understand that despite all estimates of the success of the treatment there are many personal biologic factors that cannot be predicted in advance that may affect its success including, but not limited to, the possible need for root canal treatment, the possibility of the fracture of porcelain or acrylic and the need to re-make or repair the restoration, the need to remove healthy tooth structure to accommodate the prosthesis, the possibility of sensitivity to temperature and chewing, the possibility of treatment by an adjunctive dental specialist, and the possibility of a loose fit necessitating use of dental adhesives for dentures. I also understand that temporary restorations are not permanent restorations and that "permanent" restorations may need repair or re-make within 15 years.

4. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I can ask for a complete recital of any possible complications.

5. I give consent to the doctor's or designated staff's use and disclosure of any oral, written, or electric health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully out lining the protection of my personal health information is available.

6. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I agree to pay a liquidation attorney fee of $200.00 and any additional amounts assessed by the court.

Appointment Guidelines

As your dental care providers we feel the need to express to you the importance of keeping the appointment time we have reserved for you. When an appointment is broken or cancelled with short notice, you are not only depriving yourself of dental care but other patients as well.

We request 4 business days advance notice to reschedule your appointment. For example, a Monday appointment would require you to contact us by Tuesday A.M. the week before. If you fail to notify us according to these guidelines, we will require prepayment in full for your next scheduled appointment.

Thank you for your cooperation!

Patient's Signature _____ Date: _____