

**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 condi-tions.



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 unforseen 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 asistant.
* 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 anaesthesia, or de-sensitization.
* radiographs (x-rays) as required for accurate diagnisis or treatment planning after consultation withme.
* occlusal (bite) adjustment and the 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 o 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 f my treatment



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| --- | --- | --- | --- | --- |
| Name | |  | | Patient |
| Signature | | |  | Parent |
| Date |  | | | Guardian |