

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 anaesthesia, or de-sensitization.
 - radiographs (x-rays) as required for accurate diagnosis or treatment planning after consultation with me.
 - 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 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