



CONSENT FOR DENTAL TREATMENT

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
3. I understand that any branch of medicine, including dentistry, can involve unanticipated results. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I was offered an option to purchase a 5 year nationwide coverage from the Dental Warranty Corporation on my treatment, if applicable.
4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if a benefit, pre-estimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.
5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office team.
6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspect of my treatment that I am unsure about.

Patient or Guardian Name

Date

Witness

Date