Informed Consent and Agreement for Dental Treatment

1. I hereby consent to allow Dr. _____ to examine my[1] teeth and obtain x-rays. I am aware that after this examination, my dentist will prepare a treatment plan for my approval.
2. Before treatment is commenced, my dentist will explain the treatment plan, as well as the risks, benefits and alternatives of treatment (including no treatment). The risks of the alternatives will also be explained to me. I will provide my written consent for all proposed procedures, including but not limited to: crowns, root canals, tooth extractions, dental implants, fabrication of bridges and dentures.
3. The costs associated with the procedure(s) included in my treatment plan will also be discussed with me. I understand that any costs associated with my dental care and treatment that are not covered by insurance are solely my responsibility.
4. I agree to provide a thorough and complete medical and dental history, including a complete list of all of the medications/dosages I am currently taking, including prescription, over-the-counter, vitamins and herbal supplements.
5. I understand that many factors are involved in successful dental treatment including but not limited to: the severity of the problem, timely arrival for scheduled appointments and my ability to follow the dentist's instructions. I acknowledge that no guarantees or assurances have been made to me concerning the outcome of my dental treatment.
6. I understand that during the course of dental treatment, unexpected conditions or complications may occur which may result in additional appointments, time and/or costs. My dentist will explain these conditions and complications when they arise. If it is necessary to refer me to a specialist for continued care and treatment, I agree that I am responsible for following up with the specialist and for all costs associated with the specialist's care and treatment.
7. I understand that emergency care will be provided only during normal office hours. Emergency treatment provided outside normal office hours is limited to relief of pain until an appointment can be made.
8. I authorize my dentist, and other billing agents, to release my dental treatment information to other health care providers and my insurance company for the purpose of treatment, payment for services and health care operations.
9. I understand that my dentist reserves the right to dismiss me from the dental practice due to misrepresentation of my medical problems, verbally or physically abusive behavior toward staff and/or noncompliance with recommendations made to me by the dentist.
10. I agree to contact the office if I am unable to keep an appointment. I understand that a failed appointment is defined as cancelling an appointment with less than 24 hours' notice or not keeping a scheduled appointment without notice. **I understand that I may be dismissed from the dental practice after two failed appointments.**
11. I acknowledge that I have had an opportunity to receive and review the Notice of Privacy Practices.

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[1] The words "I", "me" "my" and "you" refer to the patient or the individual who has legal authority to act and consent for the patient.

12. I hereby consent to dental care and treatment for myself, including but not limited to dental examination, diagnosis and /or x-rays.

13. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not pertain to me.

Patient/Relative/Guardian*	Print Name
Relationship to Patient	Date/Time
Witness	Date/Time
Interpreter (if required)	Date/Time

* The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to, the proposed examination and treatment plan, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Dentist's Signature	Date/Time

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S DENTAL RECORD.