Center Plaza DENTISTRY

x_____
Patient Initial

Informed Consent for Initial Examination and Cleaning

1. Exam and Radiographs

I understand that in order to complete a comprehensive exam for proper diagnosis and treatment planning, radiographs are required. I hereby authorize Center Plaza Dentistry to take xrays, study models, photographs or other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's needs.

Initial Here_____

2. Drug and Medication

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.

Initial Here_____

3. Anesthesia

I understand the risks involved in receiving local anesthesia ie. partial facial paralysis, inflamed tissue, adverse reactions to drugs causing cardiac arrest, miscarriage, hemorrhage, nerve damage, and/or numbness.

Initial Here_____

4. Changes in Treatment Plan

I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, with the most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make changes and additions as necessary.

Initial Here_____

5. Temporomandibular Joint Dysfunction (TMD)

I understand the symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

Initial Here_____

6. Dental Prophylaxis (Cleaning)

I understand that this type of cleaning is preventative in nature and intended for patients with healthy gums, and is limited to the removal of plaque and extremely light tartar and stain from the tooth structure in the absence of periodontal disease.

Initial Here_____

7. Dental Insurance Benefits

I understand that my dental insurance may only provide coverage for the minimum standard of care and that some recommended procedures may not be covered. I understand that depending on my plan, I am responsible for my portion (co-pay) of the procedures rendered. I understand that should my insurance decide not to cover a procedure, I am responsible for the balance.

Initial Here_____

8. Dental Material Fact Sheet

I have read and understand the dental material fact sheet regarding the type of dental material that would be placed in my mouth.

Initial Here_____

9. Broken/Late Appointment Policy

We make every effort to value your time and schedule your appointment time just for you. Should you need to cancel or reschedule, we require 48 business hours notice. I understand that failure to comply will result in a $50 missed appointment fee for every 30 minutes blocked for your procedure. (ex. 60 minute appointment block for fillings will result in a $100 missed appointment fee)

Initial Here_____

Patient Signature:_____ **Date:**_____

Doctor Signature:_____ **Witness:**_____