GENERAL CONSENT FOR TREATMENT

I, the undersigned, hereby authorize my doctor(s) to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my determined needs. I understand that x-rays are required on a yearly basis for accurate diagnosis. I understand that the use of anesthetic agents embodies a certain risk and I acknowledge that I have provided a thorough and honest report of my medical and dental history.

I understand that any treatment plans presented along with fee outlines, could change depending on the time elapsed since the initial examination and extent of dental treatment. Occasionally once the treatment plan has been started, complications may arise that dictate additional procedures or treatment. The doctors or their staff will always advise me of any changes. I understand that there is no guarantee to the outcome of any services performed.

PERIODONTAL MAINTENANCE

Periodontal maintenance is always scheduled following scaling and root planning. Please be aware there may be a patient co-payment for this service.

RESIN (TOOTH COLORED) FILLINGS

As a premier esthetic practice, we always recommend resin fillings to our patients**.** We strongly believe this to be a superior esthetic restoration. According to the terms of your insurance plan, if you chose to have resin fillings you will need to pay the difference between the amalgam (silver) and resin restoration.

Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of this office's Notice of Privacy Practices.

Signature: _____

Date: _____

For office use only:

#Individual refused to sign

#Communication barriers prohibited obtaining the acknowledgement

#An emergency prevented us from obtaining acknowledgement

Other (please specify) _____