DINOSAUR DENTAL

Consent of treatment

1700 Monroe Street

Endicott, ny 13760

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_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, my child may undergo procedures in all phases of dentistry including oral surgery (extractions), endodontics (root canals), restorative dentistry, oral pathology, pediatric dentistry, and radiography.
2. I will provide a thorough and complete medical history, supply a full list of my child’s medications with dosages, and consent to my child’s dentist communicating with their other medical practitioners to inquire about any aspect of their health history.
3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses.   I understand that any branch of medicine, including dentistry, can involve unanticipated results.
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 an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for *any* costs that mine or my child’s insurance does not cover.
5. My child’s treatment plan may change at any time and I will do my best to approach their dental care with optimism and open communication with their dentist, hygienist, and dental office staff.
6. I am welcome to ask questions about any aspects of my child’s dental care and will request information if I am confused or need more information.  I am responsible for clarifying any aspects of my child’s treatment that I am unsure about.

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Patient or Guardian Name Date