GENERAL DENTISTRY CONSENT and OFFICE POLICIES

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GENERAL DENTISTRY CONSENT

1. **EXAMINATION AND X-RAYS**

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnosis aids deemed appropriate by doctor to make a through diagnosis of my dental needs. Furthermore, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

2. **DRUGS, MEDICATION AND SEDATION**

I have informed the Dentist of any known allergies. I have been informed and understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication, and drugs that may have been given to me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control).

3. **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. I give my permission to the Dentist to stop during any procedure and make me aware of any/all changes, clinical and financial, that may affect the current treatment originally discussed and signed for. I will then be able to make a decision whether or not to continue with treatment.

4. **TEMPOROMANDIBULAR JOINT DISFUNCTION (TMJ)**

I understand that 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.

5. **DENTAL BENEFITS**

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the dentist's recommendation of optimal dental treatment.
By signing below, I also acknowledge that I have received "The facts about filling material fact sheet" booklet.

FINANCIAL POLICY

We want you to obtain the best dentistry for yourself. If you have dental insurance we will bill your dental insurance for you. We will do our best at estimating your insurance's co-pay and estimating your co-pay. However, please know these are estimates and dental insurances do not always guarantee payments that have been estimated and may provide only the minimum standard of care. The policy holder is responsible for any treatment not covered by their dental insurance. If your insurance company has not paid your account in full within 60 days, the patient's responsibility is to pay the remaining balance. Copayments are due at the time of service. We have several options available to pay for services; cash, check, credit card, and in office financing via Care Credit.

INSUFFICIENT FUNDS AND RETURNED CHECKS

Any check returned due to insufficient funds results in a $25 charge assessed to your account and a $35 charge for each additional check. There will be a $10 late fee per month for any payment that is overdue plus 1.5% interest may be added monthly to your overdue balance.

CANCELLATIONS AND FAILED APPOINTMENTS

Keeping your appointment is important to us. Failure to keep your scheduled appointment means we could have helped another patient during that time. If you need to reschedule an appointment we ask you to do so 48 hours in advance. There may be a $50 late cancellation or "no-show" fee. As a courtesy we try to remind you of your appointments.

By signing below, I acknowledge my Doctor's Office Policy and the General Dentistry Consent

PLEASE SIGN ON FRONT DESK COMPUTER WHEN ASKED TO DO SO