PROSTHO.
ENDO.
Bethesda | Rockville | Vienna

Informed Consent to Perform Dentistry

Please read this form carefully. Should you have any questions, our doctors and staff will be happy to help you.

1) I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
2) I understand x-rays, intra-oral imaging, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors but copies of certain aids are available upon request for a fee.
3) In general terms, the dental procedure(s) can include but not limited to:
   A. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride.
   B. Application of resin "sealants" to the grooves of the teeth.
   C. Treatment of diseased, or injured teeth with dental restorations (fillings).
   D. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or Infections.
4) I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.
5) I certify that if I, and/or my dependents have insurance coverage I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
6) I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.
7) The treatment I am receiving today has been explained to me. I have been given the opportunity to ask any questions, I am confident that if any questions do arise during the time of treatment, I will ask the treating specialist.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

Patient Signature: _____Date: _____

Signature of Guardian/Authorized Representative: _____