GENERAL CONSENT

_____ 1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography. Some of the procedures may be performed by a dental professional other than the dentist, including a dental assistant or dental hygienist, that have been trained to perform certain tasks and is allowable by California law.

_____ 2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my 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. Payment is due the day of service and I am responsible for the full amount owed regardless of any dental benefit policy I may or may not have. There is no guarantee that a dental benefit plan will cover work that may be performed.

_____ 5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

_____ 6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ 7. Many dental procedures require the use of dental anesthetic or numbing to complete the procedure. I understand that there are risks involved in using anesthetic which includes permanent or temporary loss of feeling and or muscle control from nerve damage, pain at injection site including muscle tightness or muscle damage that may or may not go back to the normal, allergic reaction, or other side effects.

By signing below, you acknowledge that you have read this policy and agree with the terms.

_____ _____

Patient Name (please print) Date

_____ _____

Signature (Parent/Guardian if patient is a minor) Relationship to Patient