General Dentistry Informed Consent

Name:	Chart:

1. WORK TO BE DONE (Initials) ____________

I understand that I am having the following work done:

☐ Filling ☐ Bridges ☐ Crowns ☐ Extraction's

☐ Root Canals ☐ Dentures ☐ XRays & Exams ☐ Impacted Teeth Removed

(Initials) ____________

2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and / or anaphylactic shock.

(Initials) ____________

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, for example root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any / all changes and additions as necessary.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care given to me.

I hereby authorize any of the doctors or dental auxiliaries of Dr. Ann Pham to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and is subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court cost that may be incurred to satisfy this obligation.

Should any dispute arise over dental services provided to me, that is whether any dental service rendered as allegedly unnecessary, unauthorized or was improperly negligently, or incompetently performed, said dispute will be submitted to Peer review by the local Component of The American Dental Association. The decision of Peer review shall be binding on both parties. I have read, understood, and agree to the above. I agree that a photocopy of this authorization shall be as valid and effective as the original forever. I am of legal age and legally competent to make this assignment.

Signature ______________________________ Date ______________________________

Doctor ______________________________ Witness ______________________________