Thomas family dental associates

General Consent

I, _____ (print name), consent to be a patient at Newton Corner Dental Care and agree to a radiographic and clinical examination. I also understand and consent to the following:

- During the course of treatment, I may elect to undergo procedures in all phases of dentistry including periodontics (gum therapy), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges and dentures), implant dentistry, restorative dentistry, preventative therapy, orthodontics, temporomandibular disorder treatment, oral pathology, pediatric dentistry and radiography.

- I will provide a thorough and complete medical history, supply a full list of my medications, and consent to my dentist communicating with my other medical practitioners to inquire about any relevant aspect of my health history.

- No guarantees can be made about treatment outcomes, restoration longevity, or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

- I understand and I have the right to accept or reject recommended dental treatment, and that if is my responsibility to consider the anticipated benefits, commonly known risks of the recommended procedure, alternative treatment, or the option of no treatment.

- 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.

- I am welcome to ask questions about any aspect of my dental care and will request information if I lack full understanding or need more information. I am responsible for clarifying any aspect of my treatment that I am unsure about.

- I understand that payment or the establishment of financial arrangements is required before services are rendered, and I will pay in full any cost of treatment or insurance co-payment accordingly. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved by my insurance provider, I am responsible for any costs that my insurance does not cover. I acknowledge that this dental office, like any other, has limited access to information regarding my insurance benefits, and, as such I am ultimately responsible for understanding how my unique insurance benefits may reimburse the cost of my care.

- I agree to make my best effort to keep all scheduled appointments, and I understand that this office requires a 24-hour notice for any appointment cancellation or appointment change. I understand that a $75 fee will be charged for any missed appointment or appointments canceled with less than a 24-hour notice.

Signature Date