

Roya A. Amini, D.D.S.

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Dental Treatment Consent Form

Patient: _____

1. HEALTH INFORMATION

I agree to disclose all previous illnesses and medical history. Undisclosed medical information and current medication, allergies or illness are risk factors.

2. DRUGS, LATEX, & MEDICINES

I understand that antibiotics and other medicines can cause allergic reactions and even life-threatening anaphylaxis. Also, some antibiotics interfere with birth-control pills. Latex allergy can cause rashes and itching. Epinephrine increases heartbeat and, depending on my health, may be dangerous to me.

3. NEEDLE STICK

If someone is inadvertently stuck with a needle used on me, I consent to have blood drawn for analysis.

4. FILLINGS, CROWNS, AND UNANTICIPATED ROOT CANALS

Some teeth may need a root canal even after a simple filling. Fillings and crowns do take away tooth structure and a percentage of these teeth end up needing a root canal after the filling or crown is done.

5. ROOT CANALS CAN FAIL

Root canals can fail and may require additional treatment or I may end up having the tooth extracted.

6. PORCELAIN CROWNS, VENEERS, BONDING, & COSMETIC FILLINGS

Porcelain crowns, veneers, bonding, and composite fillings are esthetically pleasing. However, I understand that if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, bonding, or filling is placed, I understand the color cannot be changed.

7. GUM TREATMENT & REQUESTING “JUST CLEANING”

If I don't floss or if I smoke, I can expect to have deteriorating gum condition. I agree that if I need gum treatment, I will not insist that I simply get a cleaning (prophylaxis).

8. EXTRACTIONS & SURGERY

I understand that all dental extractions or surgeries carry risks. Some are minor like a dry socket following an extraction. Some are life-threatening such as a post surgical infection or anaphylaxis.

9. FEE FOR ADDITIONAL OR SPECIALTY SERVICES

I understand that I may need treatment beyond what was originally planned (a crowned tooth becomes painful and will need a root canal), or I may be referred to a specialist for additional care (root canal was not successful). I agree to be financially responsible for the additional or specialty care.

10. LIMITATIONS OF INSURANCE COVERAGE

These are charges beyond what insurance will pay, e.g. nitrous oxide, temporary dentures, tapping off crowns and bridges, bleaching, or cosmetic work. Also, as a service to patients, this office will file insurance claims on your behalf. I understand that what may be quoted as my portion (co-payment) is only an estimate. I agree to be financially responsible for what insurance does not cover.

11. 24 HOUR NOTICE FOR CANCELLATION

We respect the importance of your time and we work very hard to accommodate the busy scheduling needs of all of our patients. We ask that patients make every effort not to change reserved dental appointments. Broken and missed appointments create scheduling problems for other patients as well as the practice. If you find that you must change your appointment, we require a minimum of 24hour notice so that we may accommodate another patient. A charge will be applied for any broken and missed appointments without advanced notification.

12. REQUESTING RECORD TRANSFER

Professional courtesies are between dentists. I agree not to requests records until I have a new dentist. Once I have chosen a new dentist I give consent to Allen Dentistry to transfer my records.

I do not expect guarantees in dental care. I have read the above and consent to treatment.

Thank you for your cooperation and for allowing us to serve all of our patients.

Signature of Patient or Parent of minor

Date

Witness