Aesthetic Dental
DENTURES & IMPLANTS

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Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information, before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of this form.

1. Treatment to be provided. I understand that, during the course of my treatment, the following care may be provided;
Examinations, Preventative Services, Restorations, Extractions, Crowns, Bridges, Dentures and any other treatment which may be recommended. _____
Patient Initials

2. Drugs and Medications. I understand that antibiotics, analgesics, and other medications can cause allergic reactions. I have notified my dentist of all my known allergies. _____ Patient 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 found during examination, the most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make any/all changes and additions as necessary. _____Patient Initials

4. I give permission to Aesthetic Dental to bill my dental insurance provider for treatment provided to me, if applicable. I understand that I am personally responsible for payment of all services rendered to me by Aesthetic Dental. _____Patient Initials

_____ _____
Patient and or legal guardian signature Date