

## CONSENT FORM

I give my consent to use local anesthetics, relaxants, anti-inflammatories, antibiotics, antihistamines, steroids or pain medication if deemed necessary for the completion of any medical or dental treatment.

I do grant permission to take photographs of my mouth or head and neck to be used, without revealing my identity, for the furthering of medical and dental knowledge and education.

I understand that the whenever a tooth is extracted, there is the possibility of infection, bone fracture treatment, temporary paresthesia (Numbness) of the lip, gum, tongue and /or facial skin. It is possible, although rare, that the paresthesia would be permanent.

I understand that root canal treatment is an attempt to retain a tooth that would otherwise require extraction. Although root canal treatment has a high degree of success, it cannot be guaranteed. Occasionally a tooth undergoing root canal treatment may undergo acute infection. It may require retreatment, surgery or (rarely) extraction. Restoration with a crown should always follow root canal treatment. Sometimes a post is also indicated.

I understand that preparation of teeth for crowns, bridges and fillings may, on occasion, traumatize the pulp (nerve). If the pulp (nerve) is in a weakened condition, this may necessitate a root canal treatment on that tooth in the future. Women taking birth control pills should be aware, that antibiotics, such as penicillin or erythromycin could possibly counteract the effects of the pill and you could become pregnant.

I realize that any of the work that the doctor proposes can be performed by a specialist. I will tell the doctor or his staff if I desire that a specialist perform the work.

Finally, I realize that any costs incurred during treatment are my responsibility. I realize that my insurance will help pay part of my treatment and that any estimates quoted to me are only estimates. I will be ultimately responsible for anything left unpaid by the insurance company. I understand that I will be charged interest on any unpaid balance, at a monthly rate of 1.5%. I further agree to pay all finance charges, collection cost, 30% attorneys fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

I understand that if I fail to give a 24 hour notice, to cancel a scheduled appointment, that I can be charged a fee up to the amount of the scheduled appointment procedure. I also understand that any X-ray taken is property of the dentist, and a fee may be charged for any duplication or transfer of said X-rays. I have not taken any mood or mind altering drugs prior to signing this form.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_