# GENERAL DENTISTRY CONSENT FORM

Date:

Last Name: First Name: Birthdate:

1. Examinations and X-Rays:

I understand that the initial visit may require radiographs or photos to complete the examination, diagnosis and treatment plan. Also, it may include cleaning, fluoride and/or sealants.

Initials:

2. Drugs and Medications:

I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).
I undertand that failure to take medications prescribed for me, in the manner prescribed may offer risks of continued or aggravated infection, pain and potential resistance to treatment of my condition.

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 teeth that were not discovered during examination, the most common being additional decay on adjacent tooth. I give my permission to the Dentist to make any or all changes and additions as necessary.

Initials:

Signature of Patient, Legal Guardian, HCP or POA

Please print name of Patient, Guardian, HCP or POA Relationship to Patient: