

## General Consent

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Date: \_\_\_\_\_

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, oral pathology, pediatric dentistry, and radiography. Some of the procedures may be performed by a dental profession other than the dentist including a dental assistant or dental hygienist that have been trained to perform certain tasks and is allowable by Indiana law.
2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
4. Payment is due the day of service and I am responsible for the full amount owed regardless of any insurance policy I may or may not have. The practice will help in filling any forms needed for commercial insurance reimbursement and those payments will be given to the patient. There is no guarantee that an insurance company will cover work that may be performed.
5. 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.
6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.
7. I consent to photographs, video, and/or digital images taken during my care to be used for educational and marketing purposes. I understand that any images used publicly will be limited to clinical views (such as teeth and oral structures only) and will not include identifying features. I further understand that clinical images may be used as necessary for treatment planning and communication with dental laboratories or other specialists. I may opt out of marketing use at any time by notifying the office in writing.

Most dental procedures require the use of dental anesthetic or numbing to complete the procedure. I understand that there are risks involved in using anesthetic which includes permanent or temporary loss of feeling and or muscle control from nerve damage, pain from injection site including muscle tightness or even muscle damage that may or may not go back to normal, allergic reaction, and any other side effects.

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Patient, Parent or Guardian Signature