Standard Consent for Dental Procedures

Please Read This Form Carefully

I, _____ authorize Dr. Flener or Dr. Taylor and their assistants to perform on me the procedure(s) that have been explained to me. I have been advised of the risk, advantages, disadvantages and the consequences of non-treatment. I authorize them to do whatever is deemed advisable if any unforeseen condition arises during the course of this procedure(s).

I further consent to the administration of local anesthesia, antibiotics, or any other drug that may be deemed necessary for dental treatment and I understand that there is a risk inherent in the administration of any drug or anesthesia. The risk includes adverse drug response: allergic reactions, cardiac arrest, aspiration, pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medication or drug. I have been informed and I fully understand that inherent with any type of procedure(s) there are certain unavoidable complications such as: post-procedure bleeding, swelling or bruising, discomfort, stiff jaw. I realize that in spite of the possible complications and risks, my procedure(s) is necessary and desired by me.

I am aware that unknown conditions found may change the treatment recommendations and the fee discussed with me. I understand that I will be informed of any changes to my procedure(s) at the earliest convenience; however, I consent to the necessary procedure(s) deemed necessary by Dr. Flener or Dr. Taylor to treat the condition found. I acknowledge that no guarantees have been made to me concerning the results of the procedure(s) being performed.

I have provided as accurate and complete medical and person history as possible, including antibiotics, drugs and foods that I am allergic to. I will follow any and all instructions during and after my procedure(s) as it has been explained to me and will report any unanticipated reactions as soon as possible. I have had the opportunity to ask questions about my procedure(s) and explanations have been given to me prior to signing this form. I understand that additional appoints may be required and I agree to the terms of the cancellation policy already on file. I understand that Mayfield Family Dentistry will file my primary claims as a courtesy for me and I agree to pay any balance or copay at the time of service.

_____

Patient Signature Printed Name Date

_____

If minor, signature of parent or guardian Printed Name Date