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ELIZABETH RUSS
FAMILY DENTAL

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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.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all your questions are answered. By consenting to this treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important for you to 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 and 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.

Treatment to be Provided
I understand that during the course of my treatment that the following care may be provided:
Examinations___X___Preventive Services___X___Restorations___X___
Crowns___X___Bridges__X___Other_____ Patient Initials_____

Drugs and Medications
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction) Patient Initials_____

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 discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes as necessary.
Patient Initials_____

Dental Insurance
I give my permission to the dental office to bill my dental insurance provider for treatment provided, if applicable. Patient Initials_____

_____ _____
Patient Signature and/or Parent/Guardian Date

_____
Please Print Name

❑ This consent will cover my dependants (under age 18) at this office. Named below:

_____
_____
_____

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