ROCKPORT FAMILY DENTAL

227 MAIN STREET; ROCKPORT, MA 01966

Informed Consent for Dental Treatment and Procedures

1. **Recommended Treatment:** You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consent 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.

X-rays: *Proposed treatment: taking oral radiographs. Benefits of treatment: taking x-rays enables us to view dental cavities, abnormalities, development and eruption of teeth. They are necessary for proper diagnosis and evaluation purposes. Alternative treatment: none; limited visual examination. Consequences of not performing: missed diagnosis; insurance companies denying payment for your treatment. Common risk: Radiation exposure to soft and hard tissue.* ______Initial

Cleaning: *Proposed treatment: involves thorough cleaning of teeth to help heal inflamed or infected gum tissue. It involves removal of soft plaque build-up and harder calculus deposits above and below the gum line. Benefit of treatment: healthy oral environment; also reduction/elimination of bleeding, odor, and periodontal disease. Alternative treatment: referrals for periodontal surgery according to the severity of condition. Consequences for not performing: discontinued or interrupted treatment could result into further inflammation and infection of gum tissues; lead to more tooth decay, and deterioration of surrounding bone structure which could lead to tooth loss. Common risk: bleeding, soreness, swelling, infection of tissue, hot and cold sensitivity, stiff or sore jaw joint.* ______Initial

2. **Drugs and Medication**

I understand that antibiotics, analgesics, and other medication can cause allergic reactions. Symptoms could include redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). ______Initial

3. **Change of 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 dentist to make any/all changes and additions as necessary. ______Initial

5. **Consent to Contact**

I understand that the dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance using call, email or text messages. *Your mobile number is confidential & will not be shared. Message frequency may vary. Message & data rates may apply.* ______Initial

4. **Payment:** I understand that payment is due at time of service. Payment options are cash, debit or credit card or personal check. I give permission to the dental office to bill my dental insurance provider (if applicable) for the treatment provided, I understand that any portion not covered by insurance will be my responsibility to pay. ______Initial

5. I give permission to the dental office to share my x-rays or written records or insurance info to another office that we may refer you to for treatment not performed here. ______Initial

Patient/Responsible Party Signature: ___________________________ Date: ___________________