POINT Family Dentistry
COSMETIC | IMPLANT | SEDATION

INFORMED CONSENT FOR GENERAL DENTAL SERVICES

As a patient, you have the right to accept or reject any type of dental (procedure or treatment) services that are recommended by your dentist. Prior to consenting to any specific services, you should carefully consider the anticipated benefits, along with the possible complications and risk factors, as well as alternatives that may include the option of deferring treatment. Do not consent to dental services until you have discussed the potential benefits and risks with the dentist or other auxiliary dental personnel regarding the services to be rendered. Do not sign this consent until all of your questions are answered. By consenting to the recommended services, you are acknowledging your willingness to accept the possible complications and risks, no matter how small the probability of occurrence may be for any specific procedure or treatment. It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advisement regarding prescribed medications, pre-treatment and post-treatment instructions, referrals to other doctors or healthcare specialists, and that you return for scheduled appointments. If you fail to follow the advice of your dentist, this may increase the chances of having poor treatment outcomes and poor overall dental health.

Authorization for Dental Procedures and Treatment Services

I hereby authorize Point Family Dentistry to utilize radiographs, impression models, photographs, or any other diagnostic tools deemed necessary to provide thorough feedback of the patient's dental health status and provide recommendations accordingly. I hereby authorize Point Family Dentistry to provide any and all types of dental procedures, treatments, prescribed medications and therapies that may be recommended by the dentist, including any services delegated by the dentist to be performed by auxiliary dental health care personnel (DHCP). I understand and agree that during the course of receiving general dental care it may be necessary to change the treatment plan due to unexpected findings that were not evident during preliminary examinations. I have read and understand this document in its entirety, and have been given sufficient opportunity to ask questions and resolve any concerns prior to signing.

_____ _____

Printed Name of Patient Date of Birth

_____ _____

Signature of Patient (or Parent / Legal Guardian) Date of Signature

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Relationship to above-named Patient