Kwon
FAMILY DENTISTRY

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 of your questions are answered. By consenting to the treatment you are acknowledging that you have discussed all of your questions and concerns with your dentist and you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

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 advice and recommendations regarding medication, pre and post treatment instructions, referral to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the risk associated with your condition and comprise the efficiency of your treatment. If you have any questions, please ask your dentist.

Please read and initial the items below and sign at the bottom of the form.

1. **Treatment to be provided**

I understand that during my course of treatment to restore and maintain optimal oral health Kwon Family Dentistry may perform the following services including but not limited to:

·Examinations ·X-rays ·Fillings ·Crowns ·Bridges ·Hygiene/other preventive service ·Implants

·Orthodontics ·Root Canals ·Dentures ·Other

I consent to services.

Patient Initials_____

2. **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. I acknowledge that I have informed my dentist of any allergies to drugs and medications.

Patient Initials_____

3. **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 and consent to the dentist to make any/all changes with the understanding I will be notified of changes before treatment is done.

Patient Initials_____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

Patient Initials_____

Patient Signature_____ **Date_____**