Salem Pediatric Dental & Orthodontic Associates

Informed Consent

You, the patient or responsible party, 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 treatment, 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, referrals to other dentists or 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.

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

1. Treatment to be Provided - *At the first visit, only preventive services* (exam, cleaning, fluoride, radiographs, sealants*) may be completed unless otherwise directed by you*. During the full course of treatment the following care may be provided as needed: examinations, preventive services (cleanings, radiographs, fluoride application, sealants, space maintenance), restorations, extractions.

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 (severe allergic reaction).

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 to the dentist to make any/all changes and additions as necessary.

4. Access to Medical Information - I authorize Salem Pediatric Dental & Orthodontic Associates to release treatment information to my insurance company, third party payer, or other treating professionals in order to facilitate the provision of continuing care.

5. Payment - I give permission to Salem Pediatric Dental & Orthodontic Associates to bill my dental insurance provider for the treatment provided, if applicable. I understand that I am responsible for all charges, co-payments or deductibles remaining after insurance payments. Further, I am responsible for professional fees for services and supplies that are not paid for by my insurer or third party payer because they have been determined to be not covered by my insurance contract or third party payment program. If I choose to have these treatments, I understand that I will be responsible for payment for these services.

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Signature Date