Information Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

1. Work to be done: I understand that I may be having the following work done X-rays, Fillings, Bridges, Crowns, Extractions, Impacted teeth removal, Root Canals, Dentures or Other.
Patient initials _____
2. Drugs and medications: I understand that antibiotics, analgesics and other medications may cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. I have advised my dentist of any and all medications I am currently taking, including but not limited to prescription medications, over-the-counter medications, herbal remedies, and alternative medications. I further understand that failure to advise my dentist of any medications I am taking prior to starting dental work may have unforeseen negative consequences for me.
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 discoverable during previous examinations. For example, root canal therapy may be necessary following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary. These changes will be discussed with me and I will have the opportunity to verbally agree or decline the change in treatment, unless it is not practical due to a dental/medical emergency.
Patient initials _____
4. I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.
Patient initials _____
5. I also agreed to pay all collection fees inquired, in an amount not to exceed fift percent (50%) of the unpaid balance, should any unpaid balance be referred to a collection agency, in addition, should any unpaid balance due be referred to an attorney for litigation, all reasonable attorney fees and court cost shall be paid by the undersigned as allowed by the court.
Patient initials _____
6. I understand that Smile League Dental does not preauthorize for certain procedures like crown lengthening(code d4249), gingivectomy(code d4211), full mouth debridement(code d4355) or extraction of wisdom teeth, needing partially bony surgical removal(coded 7230). For these procedures, although they may be covered by your insurance(again, we do not preauthorize, and will not know), we charge our discounted plans. This applies to patients with the state insurance needing these procedures ONLY.
Patient initials _____
Signature of patient or authorized responsible party: _____Date: _____