newleaf
family dental
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General Dentist
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GENERAL CONSENT FORM

I, _____, consent to be a patient at New Leaf Family Dental and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

2. For my convenience, this office may release my information to my insurance company for the purpose of claims administration, evaluation, and financial audit. This authorization remains valid and effect from the date of signing until revoked in writing.

3. I hereby authorize my insurance carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me. As most insurance plans only pay a portion of the treatment, any portion NOT PAID or NOT COVERED by the insurance company is DUE and PAYABLE at the time of treatment unless other arrangements have been made.

4. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

5. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

6. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

7. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____

Patient or Guardian Name Printed Date

_____

Patient or Guardian Signature