



INFORMED CONSENT

I, _____, consent to be a patient at Elevate Family Dentistry and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. 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, oral pathology, pediatric dentistry, and radiography. _____
Pt Initials

2. 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. _____
Pt Initials

3. 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.

Pt Initials

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover. _____
Pt Initials

5. 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.

Pt Initials

6. 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. _____
Pt Initials

Patient, Parent or Guardian Signature

Print Name

Date

Front Office Administrator

Print Name

Date