Informed Consent
General Dental Care and X-Rays

Patient Name: ______________________ Record #: ______________

You have the right to accept or refuse dental treatment recommended by your dental provider. When a procedure or treatment requires your specific written informed consent, your dental treatment provider will have a conversation with you to describe the risks and benefits of recommended treatment, reasonable alternatives and their risks and benefits, and the risks of not pursuing the recommended treatment. You will also be required to sign an informed consent to treatment form documenting that discussion and the information you received in order to make an informed decision to accept or refuse dental care.

In addition to those procedures requiring specific individualized written informed consent, you will also come to the dental office for routine preventative care and maintenance, including dental examinations, X-rays and dental prophylaxis (cleaning) and related routine care for which the dental office will not require you to sign individualized written informed consent documents each time you visit the office.

The purpose of this form is to document your ongoing consent to routine examination, X-rays and prophylaxis each time you return for your preventative and maintenance appointments. By signing below, you authorize our office to perform any one or more of the following at each dental office visit:

- Oral Examination, Diagnosis and Treatment Planning
- Dental Prophylaxis (Cleaning) and Oral Hygiene Instructions
- Dental X-Rays

In the event you do not wish to receive any of these services, you may advise us at the time of appointment. Note that full diagnosis and treatment planning for dental conditions may require one or all of the above services, and your choice not to undergo one or more of these services at the time of any appointment may prohibit the dental provider from being able to fully identify or diagnose dental problems. This may lead to, among other things, worsening of dental conditions, periodontal (gum) disease, tooth loss and negative impact on overall oral and medical health.

I understand the recommendation of routine dental care, any fee involved, risks and benefits of treatment, any alternatives and risks and benefits of these alternatives, and consequences of not undergoing treatment. I will advise the dental professional immediately if I experience any allergic reaction or negative side effects after dental care is rendered. I have had all my questions answered and have not been offered any guarantees. I hereby give my informed written consent for routine examination, X-Rays and prophylaxis at my dental appointments.

Patient Name: ______________________ Date: ______________

Signature: ______________________

If signed by a legal representative, printed name: ______________________

Authority: ______________________