

## **General Treatment consent**

- 1) I \_\_\_\_\_\_\_, hereby authorize Dr. Alex W. Ramos/Dr. Milagros Diaz or designated staff to complete a comprehensive, periodic, or limited evaluation, take x-rays including periapical, bitewings, and panoramic, to perform a routine prophylaxis, debridement or SRP (if applicable) and oral cancer screening, make study models, take photographs, and other diagnosis aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
- 2) I have provided a thorough and complete medical history, supplied a full list of my medications with dosages, and consented to my dentist communicating with my other medical practitioners to inquire about an aspect of my health history. I also must inform my dentist of any medical changes that occur as long as I am receiving treatment at this office.
- 3) I understand that no guarantees can be made about the outcomes, longevity or prognosis of the treatments I receive. I understand that any branch of medicine including dentistry, can involve unanticipated results.
- 4) I understand that the treatment plan options given to me are based on current conditions. Due to the rapid changes that can occur, all treatment plans are subject to a re-evaluation if work not completed within 90 days.
- 5) I am the ultimate decision maker in regards to the treatments I have received at this office. I have the right to change my mind about some parts of the treatment plan. I am not obligated to receive a treatment that I have consented to. However, I understand that by doing so may

- jeopardize my oral health and put myself at risk. I will be financially and personally responsible for such risks and subsequent 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. I am responsible for clarifying any aspect of my treatment that I am unsure about.
- 7) Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care.
- 8) I agree to use the anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- 9) I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service.

NAME <mark>:</mark>		
RELAT	IONSHIP TO THE PATIENT:_	
SIGNA'	ΓURE:	
DATE:		