Dental Arts of Boston

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Informed Consent for General Dental Procedures

I_____, have the right to accept or reject dental treatment recommended by my dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

Treatment to be Provided

Following the discussion, explanation and answering of questions, I authorize the treating dentist at Dental Arts of Boston to perform the treatment listed in my treatment plan. I understand that my treatment depending on my oral health may include:

- Examinations
- Preventative Services
- Restorations
- Bridges
- Crowns
- Other treatments to be discussed

All treatments will be discussed before any procedures will be done and I will receive a treatment plan. I further understand that individual reactions to treatment cannot be predicted, and that if I experience and unanticipated reactions during the course of treatment, I agree to report them to the dentist as soon as possible._____

Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). _____

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 discovered during examination, the most common being root canal therapy following routine restorative procedures. If this occurs, I will be informed before the change is instituted. I have discussed all of the above with my dentist and all of my questions have been answered. I have been informed that the success of my treatment depends upon my cooperation in keeping scheduled appointments, following home care instructions, including oral hygiene and dietary instructions, taking prescribed medication, and reporting to my dentist any changes in health status. I acknowledge that the treating dentist or practice has not made any warranties or guarantees concerning treatments or its long term success. I understand that my dentist will inform me if there is any necessary changes to the treatment and/or additions to the treatment plan._____

Dental Insurance and Billing

I give permission to Dental Arts of Boston to bill my dental insurance provider for the treatment provided, if applicable. I understand that I am responsible for all charges, co-payments, and deductibles remaining after insurance payments have been made, I acknowledge that I have been informed that Dental Arts of Boston is not responsible or able to affect what my insurance plan or third party payer may cover. I understand all non-covered services and charges will be my responsibility. I authorize Dental Arts of Boston to release any information requested from my insurance company or third party payer in connection with their settlement of the claim; (2) permit representatives of my insurer, third party payer or administrator to review my dental record, (3) release information in my record to other dentist, facilities, or agencies in order to facilitate the provision of continuing care._____

Late Cancellation/Missed Appointment Policy

I understand if I am unable to keep my appointment I must give a minimum of 24 hours' notice. If I cancel my appointment within 24 hours or miss my appointment, I understand there will be a charge of $50/scheduled hour ($100 for Specialists). I understand this is not covered by insurance._____

Patient Signature Date

Dentist Signature Date