General Consent Form

Please read this form carefully. Should you have any questions, our office coordinators will be delighted to help you.

1. I hereby authorize and direct the dentists of Smith & Smith Smile Studio, PC and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (X-Rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

2. I understand that certain parts of the treatment may be performed by certified paraprofessionals (Dental assistants) other than the dentist.

3. I also authorize the dentists of Smith & Smith Smile Studio, PC and/or dental auxiliaries to take and to use photographs, radiographs, other diagnostic materials, and treatment records for the purposes of teaching, research, and scientific publication. The photographs shall be used for dental records and if in the judgment of the dentists or dental associates, dental research, education, or science will be benefited by their use. Such photographs, diagnostic, and treatment information may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which s/he may deem proper in the interest of medical education, knowledge, or research. It is specifically understood that in any such publication or use no patient will be identified by name. The aforementioned photographs may be modified or retouched in any way that my dentist, in his/her discretion, may consider desirable.

4. I understand x-rays, photographs, models of the mouth, and/or any other diagnostic aid used for an accurate diagnosis and treatment planning are the property of the doctor but copies are available upon request for a fee.

5. In general terms, the dental procedure(s) can include but not be limited to:
   A. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride.
   B. Application of plastic "sealants" to the grooves of teeth.
   C. Treatment of diseased, or injured teeth with dental restorations (fillings), crowns, or root canal treatment.
   D. Oral surgery: Extraction of one or more teeth, excision of hyper plastic and/or pericoronal tissue, frenectomy, exposure of unerupted tooth, and dental implant placement.
   E. Placement of space maintainers and/or replacement of missing teeth with dental prosthesis.
   F. Treatment of diseased or injured oral tissues secondary to traumatic injuries and/or accidents and/or infection.
   G. Treatment of habits, malposed (crooked) teeth, orthodontia and/or oral, dental developmental or growth abnormalities.
   H. Recommendation for treatment to be completed using conscious sedation or general anesthesia.

6. I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement.

7. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.

8. I have answered all the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if I or my dependent ever had any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

9. I authorize the dentists of Smith & Smith Smile Studio, PC to forward a review of findings and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care giver for his/her records, as well as any third parties such as insurance companies who may request information.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

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Patient Name ____

Person Authorized to Consent_____________________ Relationship to Patient____________

Signature____ Date________________________