SOUTHERNHEIGHTS
DENTAL GROUP

General Consent Form

I, ____, consent to be a patient at the above named office and agree to a radiographic and clinic 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, temporomandibular disorder treatment, restorative dentistry, sleep apnea treatment, oral pathology, pediatric dentistry and radiography.

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.

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.

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

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.

6. I am welcome to ask any 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.

7. I understand that any missed appointments without 24 hours notice may result in same day only scheduling and/or a missed appointment fee.

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Print Patient or Guardian Name   Date

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Signature of Patient or Guardian