Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your 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 have been 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.

Treatment to be provided

I understand that during my course of treatment that the following care may be provided. *Please initial each treatment type below.*

Examinations ____________ Preventative Services ___________ Restorations _____________

Crowns _____________ Bridges ___________ Other _____________

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). **Patient Initials** _______

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. I give my permission to the dentist to make any/all changes and additions as necessary. **Patient Initials** ________

Insurance Billing

I give permission to Mary C. DeMello, D.M.D. to bill my dental insurance provider for the treatment provided, if applicable. **Patient Initials** _______

Print Name: ____ Date: __________________

Signature: ____

Appointment Cancellation Policy

Here at the office of Mary C. DeMello, D.M.D. we strive to provide the best quality oral health care for all of our patients. This requires a commitment and dedication to handle your care in as timely a manner as possible. In order to achieve this, we must schedule appointments that accommodate the greatest number of patients each day. Without enough prior notice of a cancellation, a patient in need may have to wait longer than necessary for an appointment. We fully understand that scheduling conflicts come up but in order to keep up with the demand for appointments, we have a cancellation policy that requires a minimum of 48 hours' notice. We confirm appointments by email, phone and text which gives adequate opportunity to resolve any conflicts or reschedule if needed. Of course each situation will be considered individually, however a charge may be incurred when 48 hour notice is not given. We hope you can see how this will benefit all of our patients.

Print Name: ____ Date: ________________

Signature: ____

Acknowledgement of Receipt

Notice of Privacy Practices

I have received a copy of the office of Mary C. DeMello, D.M.D. Notice of Privacy Practices.

Print Name: ______________________________________ Date: _______________

Signature: ____

✰ **You may refuse to sign this acknowledgement of receipt** ✰

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (please specify)

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