Turnage Family Dentistry

Consent for Dental Treatment

I,_____, hereby give Dr. April Turnage,DMD and staff, my consent to perform dental treatment considered necessary.

MEDICAL HISTORY INFORMATION Initial_____
Please understand that it is important that you divulge any information about your medical history to your dentist. It is important that you inform us of any medicines that you are taking each time you come to an appointment as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics, or other medications. Please be sure to provide us with a list of any drug allergies you have.

RESTORATIONS Initial_____
I understand that care must be exercised in chewing on fillings until directed by the doctor or staff to avoid breakage or soft tissue damage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that sensitivity may occur after a newly placed filling.

CHANGES IN TREATMENT Initial_____
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, for example, root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changed and additions as necessary after consultation.

INSURANCE,FEES AND PAYMENT Initial_____
When treatment plans are presented the expected insurance payment is an estimate. If for any reason the insurance company does not pay the amount estimated, I will be responsible for the difference. As a courtesy, we will file your insurance claim for you. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by you insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations: therefore, the amount due to our office may be adjusted accordingly. If insurance has not paid on a claim within 60 days, the balance becomes the patient's responsibility. We will make any reimbursement after insurance payment is received. Payment for service is expected at the time service is provided. If an extended payment plan is desired, please ask us about the Care Credit program.
I am also aware that there will be a $40.00 return check fee if payment is returned for any reason. This may also result in being reported to District Attorney's office.

COMPLICATIONS Initial_____
I understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following my treatment. I agree to report them to the office as soon as possible. I acknowledge that no guarantees or assurances have been given to anyone as to the results that may be obtained. Complications resulting from the use of dental instruments, drugs, sedation, medicines, and analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheek, and teeth (which is transient, but on infrequent occasion, may be permanent), reaction to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure. The risks of complications from medications used/prescribed with general dental treatment include, but are not limited to, drowsiness; lack of awareness and coordination, nausea, allergic reactions, etc. 9which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). [it is not advisable to operate any motor vehicle or hazardous device while experiencing side efforts of the medications we may prescribe.]
[Antibiotics are known to decrease the effectiveness of oral contraceptives, so it is advised that other contraceptive measures be taken during the administration of antibiotics.]

X-RAYS AND PHOTOS Initial_____
Modern dental x-ray equipment allows the use of extremely low-dose radiation. Diagnostic x-rays provide the dentist with valuable information about your teeth and supporting done that cannot be evaluated otherwise. Our office takes the minimum x-rays to allow us to do a thorough exam for each patient. All patients 18 years and older will receive a full mouth series of intra-oral x-rays. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw. We may also take phots of our patients as part of their permanent record. We will not release these phots to anyone without your permission.

SPECIFIC PROBLEM EXAMINATIONS Initial_____

In the event that a patient request only a specific problem be address (broken tooth, pain in one area, etc) this is considered a problem-focused evaluation. Please understand that this appointment will be for the treatment/diagnosis of an emergency/urgent need. X-rays will be taken in the specific area only, and a complete comprehensive examination will not be done unless requested. The dentist cannot diagnose problems in other areas of the mouth. Any future treatment of other areas will require additional x-rays and a complete exam.

MINORS Initials_____

We must receive written consent prior to performing any non-emergency dental procedures on a minor. Grandparents, step-parents, friends, relatives, etc. are not legally allowed to consent to dental procedures, unless they have been given written consent by the parent or legal guardian. Please do not send your child to an appointment alone or with someone other than yourself, unless you have filled out any necessary consent forms prior to the appointment, otherwise we may have no choice but to reschedule your child's appointment to another day.

REQUEST FOR RECORDS/X-RAYS Initial_____

By law we are required to keep a patient's original x-rays and record in this office. Original x-rays or records will NOT be released. Th patient or a designated person may request copies of their x-rays or records; however, there is a fee for duplication. We also require a minimum of five (5) days' notice to copy x-rays and process records for pick-up. There is no fee for us to send x-rays to a specialist that we refer you to.

SPECIALTY REFERAL AND/OR SECOND OPINION Initial_____

General dentists perform the majority of all dental treatment today. However, we want all patients to be aware that specialty fields exist in dentistry, particularly in the fields of oral surgery, orthodontics, periodontist, pediatric dentistry, and endodontics. In some cases we may have to refer certain procedures out to a specialist. We would be happy to offer you the names of specialists in order for you to have a second opinion and/or have actual treatment performed by a specialist.

MISSED APPOINTMENTS Initial_____

We reserve a specific block of time for each of our patients. An appointment with you is a bond of trust that we will be here to serve you. We expect you to be present for each of your appointments. It is extremely difficult to provide you with the kind of treatment that you expect from us with constant short notice changes to our schedule. If missed appointments become problematic for any patient, we reserve the right to charge $25 for all cancellations/no show appointments made less than 24 hours in advance. Verifiable sickness and emergencies will be excluded from this charge.

I hereby authorize the dental staff of Turnage Family Dentistry, PLLC to perform necessary examinations, and take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. I also give authorization to proceed with dental restorations and treatment as explained to me. I understand that dentistry is not an exact science and that reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized. I understand my treatment plan is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment.

I understand the regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any collection fees, attorney's fees, or court costs that may be incurred to satisfy this obligation. I have had the opportunity to read this form and ask questions, and my questions have been answered to my satisfaction.

_____ _____

Patient or guardian Signature Date

_____

Office Staff Initial