JAWMAN DENTAL

GENERAL CONSENT TO DENTAL PROCEDURES & OFFICE POLICIES

Patient: _____

Date of Birth: _____

REGARDING MY MEDICAL HISTORY:

_____ (INITIALS) I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify Dr. Michael Steinberg or Dr. Joshua Steinberg of any changes at any subsequent appointment.

REGARDING GENERAL CONSENT TO DENTAL PROCEDURES:

_____ (INITIALS) I do hereby authorize and request the performance of dental services by Dr. Michael Steinberg, Dr. Joshua Steinberg and such associates or employees either may designate, and the use of whatever procedures the doctors may deem necessary or advisable to maintain my dental health, or the dental health of any minor or other individual for which I am responsible for treatment. Any restorative treatment or therapy such as crowns, fillings and extractions will require my additional consent to treatment.

REGARDING ANESTHESIA:

_____ (INITIALS) I authorize for myself, and any minor or other individual for which I have responsibility, the administration of any anesthetics, analgesics or sedative, including without limitation, nitrous oxide, therapeutic and/or other pharmaceutical agents (including those related to restorative, palliative, therapeutic, or surgical treatment) that may be deemed appropriate by Drs. Michael or Joshua Steinberg. I understand that anesthetics may be therapeutic, diagnostic, or for treatment of facial pain. I understand that antibiotics, anesthetics, analgesics and other medications may cause complications and reactions including without limitation allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I understand that additional complications may include, but are not limited to, pain, swelling, bruising, temporary limited opening, hematoma, cardiac stimulations, muscle soreness, temporary or permanent numbness, and local infections. I understand that in occasional cases, the anesthesia may be prolonged and in very rare cases, permanent.

REGARDING DENTAL TREATMENT:

_____ (INITIALS) I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since the initial examination and the extent of dental pathology. I understand that once the treatment plan has begun, complications may arise that dictate additional procedures or treatment. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I authorize Dr. Michael Steinberg and/or Dr. Joshua Steinberg to make any/all changes and additions as necessary.

_____ (INITIALS) I understand that a more extensive restoration than originally planned, including but not limited to root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely “permanent” and usually require periodic replacement with additional fillings and/or crowns.

_____ (INITIALS) I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I will receive.

_____(INITIALS) I realize and acknowledge that there are risks and/or complications associated with dental procedure. I understand that should any of the risks occur during or as a result of my dental treatment, Drs. Michael or Joshua Steinberg may refer me to a specialist or medical doctor for further treatment of my dental condition and/or any treatment required due to the associated risk. Some of the possible complications and/or risks may include, without limitation:

1) Allergic reactions from local anesthetics, medicated rinses, latex gloves, prescription medication, or other products used in the treatment of dental conditions.

(over)

2) Trauma to adjacent oral structure, such as teeth, gums tongue, cheek, lip or face.
3) Irreversible pulpitis, necessitating root canal therapy or extraction, due to extent or depth of decay and/or the amount of tooth structure prepared as prescribed for treatment of tooth.
4) Permanent or temporary numbness associated with the administration of local anesthetic, extraction of teeth, root canal therapy, infection, or other oral surgical procedures.
5) Pain or discomfort associated with the TMJ or jaw joint.
6) Elevated tooth sensitivity to hot, cold, sweat, pressure, air, and chewing or biting.
7) Aspirating (breathing in) or swallowing dental instruments, dental products or tooth structures.
8) Breakage of dental instruments such as root canal files, dental burs, dental hand instruments.

REGARDING OFFICE POLICIES:

_____ (INITIALS) I hereby agree to show up for my scheduled appointments on time and to give a 48 hour advance notice if I need to cancel or reschedule an appointment. I understand that a $110 fee may be assessed to my account without at least 48 hours advance notice of cancellation. I also understand that all cancellation fees must be paid prior to scheduling another appointment. A broken appointment is a loss to three people --- the patient who missed the valuable time, the patient who could have taken the valuable time; and the doctor who was fully staffed and prepared for the appointment.

_____ (INITIALS) I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation. I agree that if my credit card or debit card charge is placed in dispute for any reason whatsoever, I will pay to Dr. Michael Steinberg a collection processing fee of $25 in addition to the original charges due on the transaction.

_____(INITIALS) **I authorize this dental office to email all or part of my patient records to me, others or dental/medical specialists upon my written direction and using unsecured emails.**

CONSENT: *I have had the opportunity to have all my questions answered by Dr. Michael Steinberg and/or Dr. Joshua Steinberg, and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent*.

_____ _____
Patient / Guardian Signature Date

_____
Print Guardian Name (if applicable)

For Guardians, please note your relationship to patient: _____

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