Dental Informed Consent

Name of Patient: _____

Your child is a dental patient of Taylor D. Everett, D.D.S. We will provide you a copy of his/her dental treatment plan as the need arises. Such treatment will be performed only if you agree that it be done. By allowing the School Based Health Center to make an appointment for treatment, you are agreeing to the treatment described on the treatment plan.

Our dental treatment will likely involve the administration of anesthesia by injection or pre-medication. The administration of anesthesia can create certain risks. Those risks include: bleeding, temporary or permanent pain, infection, temporary or permanent nerve damage, allergic reaction, or the inability to drive a car or operate machinery for a certain period.

He/She must follow any regimen we suggest, either pre-treatment or post-treatment. This regimen may include taking antibiotics, rinsing with certain solutions, coming to us for follow-up appointments, tooth flossing and brushing, or the avoidance of certain foods.

After treatment he/she must remain in our office until we release you. If he/she does not recover completely from anesthesia, please inform us immediately so that we may take appropriate action.

By signing this consent, you are also agreeing to accept full financial responsibility for any services rendered to your child. This financial responsibility includes the entire account balance, or the percentage that your insurance does not cover. You understand that failure to pay this balance can result in your account balance and information being transferred to a collection agency.

I have read and full understand all of the above matters.

Signature (Parent/Guardian if a minor):_____

Date: _____Witness signature: _____