Kutina

Dental Office

DENTAL TREATMENT INFORMED CONSENT FORM:

I do authorize and give consent to KUTINA DENTAL OFFICE, the Dentist and his staff to administer treatment, including but not limited to local anesthesia and other such treatment, which, in their judgment, may be necessary for the prudent exercise of medical and dental care.

I understand that during the procedure(s) unforeseen conditions may arise that necessitate different procedures from those planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment of the Dentist and his staff.

I understand that drugs and medications that have been administered or prescribed by KUTINA DENTAL OFFICE, the Dentist or his staff may cause allergic reactions causing redness, swelling, itching, pain, vomiting, anaphylactic shock (severe allergic reaction) and/or death.

I acknowledge that my medical and dental history given have been completed fully and accurately to the best of my ability. I also agree, that if there is ever a change in my medical or dental history, I will inform KUTINA DENTAL OFFICE, the Dentist or his staff of such change.

I also agree that I will be responsible for any fees incurred that I have elected to do either out of necessity or for cosmetic reasons that my insurance company deems unnecessary. And in addition, I will be responsible for any outstanding fees incurred on the collection of my account or any account of my dependents.

I understand that dentistry is not an exact science and that, therefore, KUTINA DENTAL OFFICE, the Dentist and/or his staff cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made be anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of patient_____Date_____

Signature of Parent/Guardian if patient is a minor_____