

FLORESTA PLAZA DENTAL
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INFORMED CONSENT

WELCOME TO OUR FAMILY AT FLORESTA PLAZA DENTAL, WE ARE HERE TO PUT A SMILE ON YOUR FACE. IT IS OUR MISSION TO PROVIDE YOU WITH THE BEST QUALITY DENTAL CARE POSSIBLE. AND TO DO SO, WE RELY ON OUR HONESTY, OUR MORALITY AND OUR STRONG ETHICAL NATURE.

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE.

I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS AND DENTAL COVERAGE.

I AUTHORIZE THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICES, SUCH AS X-RAYS, STUDY MODELS, PHOTOGRAPHS OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS.

I UNDERSTAND THAT ADMINISTRATION OF LOCAL ANESTHESIA MAY RESULT IN RISKS AND COMPLICATIONS NOT LIMITED TO PAIN, SWELLING, BRUISING, INFECTION, AND NERVE DAMAGE.

I ALSO AUTHORIZE THE DOCTOR (AND HIS/HER EMPLOYEES FOR ASSISTANCE WHEN APPLICABLE) TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION AND THERAPY WITH MY INFORMED CONSENT IN CONNECTION WITH MY DIAGNOSIS AND TREATMENT PLAN.

EVEN THOUGH I MAY HAVE DENTAL INSURANCE COVERAGE, I UNDERSTAND THAT PAYMENT FOR SERVICES RENDERED IS MY RESPONSIBILITY. IT IS MY UNDERSTANDING THAT PAYMENT IS DUE AT THE TIME OF SERVICE, UNLESS OTHER FINANCIAL ARRANGEMENTS HAVE BEEN MADE.

PATIENT SIGNATURE: _____ DATE: _____