ZORA FAMILY DENTAL

GENERAL DENTAL TREATMENT CONSENT FORM

Patient Name: _____ Date of Birth: _____

Thank you for choosing ZORA FAMILY DENTAL for your dental care. Please read this form carefully. It explains the potential benefits, risks, and alternatives of general dental treatment. If you have any questions, please discuss them with your dentist before signing.

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1. Recommended Procedures

I authorize **Dr. Zora and/or Dr. Sullivan** and any designated dental staff to perform the dental diagnostic and treatment procedures deemed necessary or advisable for my oral health. This may include, but is not limited to:

- Comprehensive examinations, digital X-rays, and diagnostic photographs.
- Dental cleanings (prophylaxis), periodontal scaling, and root planing.
- Local anesthetics to manage comfort during procedures.
- Restorative treatments (fillings, crowns, bridges, and inlays/onlays).
- Endodontic therapy (root canals).
- Implants
- Oral surgery (simple and surgical extractions).

2. Changes in the Treatment Plan

I understand that during a procedure, clinical conditions may reveal that a different or additional treatment is necessary (for example, a deep cavity turning into a root canal). If this occurs, the dentist will explain the situation and obtain my verbal or written consent before proceeding, unless it is an immediate emergency.

3. Risks Associated with Dental Treatment

While dental procedures are generally safe, I acknowledge that no treatment is completely without risk. Potential risks include, but are not limited to:

- **Infection or Swelling:** May occur post-operatively and may require antibiotics.
- **Bleeding:** Standard during surgical or periodontal procedures; prolonged bleeding is rare but possible.
- **Anesthetic Reactions:** Bruising at the injection site, temporary numbness, or rare allergic reactions.
- **Sensitivity or Pain:** Temporary tooth sensitivity to hot, cold, or biting pressure following restorations.

- **Nerve Damage:** Rare risk of temporary or permanent numbness of the lip, tongue, chin, or cheek following injections or extractions.
- **Damage to Existing Work:** Neighboring teeth or restorations could be chipped or loosened during treatment.

4. Patient Responsibilities & Compliance

- **Accurate Health History:** I certify that I have provided a complete and accurate medical and dental history, including all current medications, allergies, and health conditions.
- **Follow-Up Care:** I understand that success depends heavily on maintaining excellent home care and attending all recommended follow-up appointments.

5. Financial and Insurance Policy

- I understand that I am ultimately responsible for all fees associated with my treatment, regardless of insurance coverage.
- Estimates provided are not a guarantee of insurance payment. I agree to pay any co-pays, deductibles, or non-covered balances at the time of service.

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have read and fully understand this form. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I voluntarily consent to the recommended dental treatment.

Patient / Legal Guardian Signature: _____

Relationship to Patient (if Guardian): _____

Date: _____

Witness Signature: _____

Date: _____