CONSENT FOR DENTAL TREATMENT AND XRAYS

I understand that I am having an examination to evaluate my overall health, well-being and oral conditions. This will include a thorough review of my medical history, medications and any allergic reactions or adverse drug reactions that I may have experienced in the past. I understand that in order for Dr. Moreau to complete any examinations, it will be necessary for me to provide her and her staff with a complete medical and dental history.

I also understand that Dr. Moreau may prescribe certain X-rays to be taken in addition, to allow for evaluation of certain dental conditions, such as, but not limited to, periodontal disease, dental decay, root canals, etc. I understand that Dr. Moreau may make recommendations for treatment, and she will do her best to explain this treatment and give alternative options.

I also understand that Dr. Moreau and her staff, take my health seriously and have chosen to limit my exposure to dental X-rays, by using lead aprons with thyroid collars and digital radiography, which significantly reduces my X-ray exposure.

I understand that in dentistry, antibiotics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction that requires immediate medical attention).

I acknowledge that no guarantee or assurance has been made by 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_____

Patient Name(Print)_____

Signature of Parent or Guardian if minor_____ Date _____

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