PDA DENTAL GROUP
PEDIATRIC | ORTHODONTIC | ADULT

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Informed Consent for Dental Procedures

You have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks for the recommended procedure, alternative treatment, or the option of no treatment.

Do not consent to treatment until you discuss potential benefits, risks and complications with your dentist, and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post-operative instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist you may increase the chances of a poor outcome.

Please read and sign the items below.

1. **AUTHORIZATION** – I hereby authorize and direct the dentists and staff of PDA Dental Group to provide dental care for myself/my child.

   Initial _____

2. **TREATMENT TO BE PROVIDED** – I understand that during the course of treatment the following care may be provided: Examinations, preventative services, radiographs, restorations, extractions, space maintainers, and crowns.

   Initial _____

3. **DRUGS AND MEDICATIONS** – I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

   Initial _____

4. **CHANGES IN TREATMENT PLAN** – I understand that during the treatment it may become necessary to change or add procedures because of the conditions that were not evident during prior examination.

   Initial _____

5. **ASSIGNMENT OF BENEFITS** – I give permission to the dental office to bill my dental insurance provider for the treatment provided. I authorize payment directly to the dentist of the group insurance benefits otherwise payable to me.

   Initial _____

Patient's Full Name (please print) _____

Parent/Guardian Name if applicable (please print) _____

Patient/Parent/Guardian Signature _____ Date _____