

VI H. TRUONG-MAI, DDS, FAGD

DENTAL TREATMENT CONSENT FORM

Patient Name: _____

1. **Health Information**

I agree to disclose all previous illnesses and medical and dental history (i.e. gum disease). **UNDISCLOSED MEDICAL INFORMATION—past surgeries, current medication, allergies are risk factors.** I agree to allow the use of my information only where it is necessary to process insurance claims.

2. **Drugs, Latex and Medicines**

I understand that antibiotics and other medicines can cause allergic reactions and even life-threatening anaphylaxis. Also, some antibiotics interfere with birth-control pills. Latex allergy can cause rashes and itching. Epinephrine increases heart beat and, depending on my health, may be dangerous to me.

3. **Needle Stick**

If someone is inadvertently stuck with a needle used on me, I consent to have blood drawn for analysis.

4. **Fillings, Crowns and Un-anticipated Root Canals**

Some teeth may need a root canal even after a simple filling. Fillings and crowns do take away tooth structure and a percentage of these teeth end up needing a root canal **after** the filling or crown is done.

5. **Root Canals can fail**

Root canals can fail and may require additional treatment or I may end up having the tooth extracted.

6. **Porcelain Crowns, Veneers, Bonding and Cosmetic Fillings**

Porcelain crowns, veneers, bonding and cosmetic fillings are esthetically pleasing. However, I understand that if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, bonding or filling is placed, I understand the color cannot be changed.

7. **Gum Treatment and Requesting "Just a Cleaning"**

If I don't floss or if I smoke, I can expect to have deteriorating gum condition. I agree that if I need gum treatment, **I will not insist that I simply get a cleaning (prophylaxis).**

8. **Extractions and Surgery**

I understand that all dental extractions or surgeries carry risks. Some are minor like a dry-socket following an extraction. Some are life-threatening such as post-surgical infection or anaphylaxis.

9. **Fee for Additional or Specialty Care**

I understand that I may need treatment beyond what was originally planned (a crowned tooth becomes painful and will need a root canal), or I may be referred to a specialist for additional care (root canal was not successful). **I agree to be financially responsible for the additional or specialty care.**

10. **I agree to pay what Insurance does not cover**

There are charges beyond what insurance will pay, i.e. nitrous oxide, temporary dentures, tapping off old crowns or bridges, bleaching or cosmetic work. Also, as a service to patients, this office will file insurance claims on their behalf. I understand that what may be quoted as my portion (co-payment) is only an estimate. **I agree to be financially responsible for what insurance does not cover.**

11. **24 Hour Notice for Cancellation**

I agree to give 24 hour notice for cancellations or pay the broken appointment fee. I understand that leaving a message after the office is closed the day (or weekend) before is **NOT** sufficient notice.

12. **Requesting Record Transfers or Copies**

Professional courtesies are between dentists. I agree not to request records **until** I have a new dentist.

[Texas State Law allows the dentist to charge up to \$25 for the first 20 pages and additional fees for x-rays]

13. **Hygiene Appointments**

If I am more than 15 minutes late for my cleaning appointment, I will **either** take my remaining time only **or** reschedule **and** pay a broken appointment fee.

I do not expect guarantees in dental care. I have read the above and consent to treatment.

Signature of Patient or Parent of Minor

Date

Witness