**Marion Dental Health Associates, P.C.**

**3 Spring Street**

**Marion, MA 02738**

**508-748-0744**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Last Name First Name MI

You, the patient, 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 of the recommended procedure, alternative treatments, or the option of no treatment. Do not consent to treatment unless and 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 treatment 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 from the treatment provided.

1.**Treatment to be provided**

 I understand that during my course of treatment that the following care may be provided under this consent form: examinations, diagnostic procedures, preventive procedures, local anesthesia, restorative procedures, and other procedures.

2. **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).

3. **Changes in the Treatment Plan**

 I understand that during treatment, it may be necessary to change or add procedures because of the conditions found while working on your teeth that were not discovered during the initial examination. The most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

4. **Insurance (if applicable)**

I agree to be responsible for all charges for dental services and materials not paid by my dental plan, unless prohibited by law, or a contractual agreement is in place between my dental plan and Marion Dental Health Associates PC prohibiting all or a portion of such charges. To the extent permitted by law, I consent to the use and disclosure of my protected health information to carry out payment activities in connection with my treatment. I also authorize and direct payment of the dental benefits otherwise payable to me, directly to Marion Dental Health Associates PC.

By signing, I acknowledge that I have read this consent form and agree to the contents.

Response Date: Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_