Northampton Implant and Family Dentistry
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Informed Consent for General Dental Procedures

You, the patient, or the named patient (if a minor), _____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 the 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 specialists and return for scheduled appointments. If you fail to follow the recommendations of your dentist, you may increase the chances of poor outcomes.

Please read and initial the items below and sign the button of the form.

1. **Treatment to be Provided**
   I understand that during my course of treatment, the following care may be provided: Examination, Preventative Services, Restorations, Crown, Bridges, Root Canal, Extractions, Implants, etc. (Patient/guardian initials _____)
2. **Drugs and Medications**
   I understand that antibiotics, analgesics and other medication can cause allergic reactions, leading to redness and swelling of tissues; pain, itching, vomiting, and or anaphylactic shock (in severe cases). (Patient/guardian initials _____)
3. **Changes in Treatment Plan**
   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the 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.
   (Patient/guardian initials _____)
4. **I give permission to my dental office to bill my dental insurance provider for the treatment provided, if applicable.** (Patient/guardian initials _____)

_____ _____

Patient or Guardian Signature Date