Ramzi Sawabini, D.D.S.
Toan D. Nguyen, D.D.S.

BASIC DENTAL TREATMENT CONSENT FORM

WORK TO BE DONE:
I understand that I am having the following work done: Cleaning, X-rays, Examination, and use of General Anesthesia if needed for treatment.

Initials________

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

Initials_________

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 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.

Initials_________

Read this entire section carefully

THE PURPOSE OF THIS SECTION IS TO MAKE YOU AWARE OF THE FOLLOWING:

You may have to pay for services, balances or items your insurance does not cover or denies. Payment on your account will be patients responsibility (or Guarantor), for we do not rely on payment from your insurance company, liens, secondary insurances, or third party liens. San Dimas Family Dentistry bills your insurance as a courtesy to you.

I, ______________________________, understand and am aware of the financial responsibility for this account.
(print patients name)

Signature: ______________________________ Date:______________

______________________________ Date: ______________
Signature of Parent/Guardian if patient is a minor

WITNESS: San Dimas Family Dentistry Date: ______________