WILBUR FAMILY DENTISTRY
DANIEL B. FENN, D.D.S.

GENERAL CONSENT FOR TREATMENT

I consent to be a patient of record at Wilbur Family Dentistry and agree to an initial radiographic (x-ray) and clinical examination.

I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery (extractions, etc), endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history. I understand the importance of my health history and affirm that I have given any and all information that may impact my care. I understand that failure to give true health information may adversely affect my care and lead to unwanted complications

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that, like any branch of medicine, dentistry is not an exact science and can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. As a courtesy, the staff at Wilbur Family Dentistry will attempt to bill my dental insurance for services that are rendered. **I understand that, even if an insurance coverage estimate is given or a procedure has been pre-approved, I am still responsible for any costs that my insurance does not cover if a claim is denied.**

5. My treatment plan may change at any time based on new findings or developments. I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____

Patient, Parent, or Guardian **Date**

_____ _____

Witness **Doctor**