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Diplomate of the American Board of Endodontics
Fellow of the American College of Dentists
Practice Limited to Endodontics

Consent For TeleDentistry

I am acknowledging that I wish to receive a TeleDentistry consultation with my Dentist. In the absence of radiographs (x-rays), I understand that I may be asked to send photographs or other documentation as requested by the Dentist. I will try to provide as much detailed information as I can. I understand that the Doctor is limited to what they are able to determine in these circumstances. I also understand that if I am experiencing pain or swelling that is life threatening I will call 911 or go to an emergency room. I understand that I am responsible for any payment resulting from this consultation. In addition, I understand and consent to this consultation being recorded for clinical documentation and accuracy.

Patient Signature ______________________________ Date ________________

Doctor Signature ______________________________ Date ________________

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