Horizons Dentistry
9353 Fairway View Pl #200
Rancho Cucamonga, CA 91730

Informed Consent

I understand that by signing below. I am requesting and authorizing the procedure(s) to be performed and I have read and understand the possible risks and complications of the procedure(s)

(1) X-Rays & Examination

I understand that I will be receiving a dental examination from a state licensed dental practitioner. I understand that while x-rays are taken of my teeth, I will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a thorough and comprehensive examination. I also understand that if I am pregnant radiation exposure posses a serious threat to the life and health of my unborn child. Pregnant women are required to have a medical release from their medical doctor prior to x-rays and dental treatment.

Initials_____

(2) Changes in Treatment Plan

I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not found during examination, the most common being root canal therapy following routine restorative procedures. I understand there may be unforeseen changes that can occur during treatment. I understand that when ever possible, I will be informed of any treatment changes in advanced. I give my permission to the dentist to make any/or all changes and additions as necessary.

Initials_____

(3) Drugs and Medication

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_____

(4) Fillings

I understand that care must be exercised in chewing with fillings, especially during the first 24 hours, to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after-effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the filling being placed.

Initials_____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners can not guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction. I also acknowledge that I am ultimately responsible for all dental fee payments regardless of any dental insurance coverage.

Signature of Patient_____ Date_____