Consent Form for Dental Treatment

Côte St-Luc Dental Clinic

Dental surgeon _____ Patient name _____

GENERAL CONSENT I consent to becoming a patient and opening a file at the Côte St-Luc Dental Clinic. I agree to provide my dentist with accurate information before, during and after treatment. I acknowledge that I have the right to accept or reject any recommended treatment and I shall discuss and carefully consider the anticipated benefits and commonly known risks of the recommended procedures, alternative treatments or even the option of no treatment with my dental team. (Initials_____)

X-RAYS I understand that radiographs are necessary to complete the dental examination and aid in visualizing dental conditions not apparent to the naked eye. In addition, I understand that radiographs should be taken at regular intervals as prescribed by the dental team. (Initials_____)

DRUGS AND MEDICATIONS I understand that it is important to provide my dental team with an updated medication list and comprehensive medical questionnaire and also to inform the Clinic of any changes to the aforementioned. I acknowledge that antibiotics, analgesics and other medications may cause allergic reactions resulting in swelling, pain, itching, vomiting, and possibly anaphylactic shock (severe allergic reaction). (Initials_____)

CHANGES IN TREATMENT PLANS I understand that it may be necessary to alter or add procedures during a treatment plan as conditions that were not apparent during examination may arise, examples being root canal therapy or extraction following routine restorative procedures. I understand, that dentistry is not an exact science and that guarantees or assurances cannot be made regarding the dental treatment which I have requested and authorized. (Initials_____)

EMAIL AND SMS COMMUNICATION I give permission for the Clinic to communicate with me by email and/or text message (SMS). The Clinic will use reasonable means to protect the security and confidentiality of e-mail or SMS communications but will not be held liable for inadvertent disclosure of confidential information. (Initials_____)

INSURANCE AND PAYMENTS If applicable, I give permission to the Côte St-Luc Dental Clinic to bill my insurance provider for treatments provided. I, the patient, shall be financially responsible for any balances not covered by the carrier. (Initials_____)

Signature of Patient/Parent _____

Date _____/_____/_____
Month Day Year