Amazing Family Dental
Consent and Agreement : General Treatment

Please read the following information carefully. Signing this document means that you: (1) understand the agreement below, (2) consent to the terms of this agreement, and (3) have had all of your questions regarding this consent and agreement answered to your satisfaction.

After you have read this consent and agreement, please sign your name below and specify your relationship to the patient as an indication of your acceptance of the terms listed below:

1. As a consenting adult, I agree to permit the dentist and **Amazing Family Dental (AFD)** staff to provide dental care to myself, my child or children, and/or my legal ward(s) as applicable.
2. I understand that all persons cannot be accepted as patients of AFD. Persons with complicating medical conditions and extremely difficult dental needs may not be accepted.
3. I understand AFD maintains the right to discontinue treatment for any appropriate reason. All records pertaining to the treatment and diagnosis of patients are the property of AFD.
4. I understand that I will be expected to pay for the treatment I receive at the time of service and that in the event my account is turned over to a collection service, I will be responsible for any additional charges pertaining to the original service and the collection process. AFD reserves the right to revise fees at any time, for any treatment which has not yet been started. I understand that during the course of my dental care unforeseen complications or new conditions may arise that may require treatment in addition to the procedures listed on the treatment plan, which may result in higher cost. Furthermore, I understand that in the event my treatment may be too complex for the dentist to manage, it may be necessary for me to be referred to a specialist in order for me to receive the care I need. Should this occur, I understand that I will be expected to pay the specialist fee for the treatment. I also understand that the price I have been quoted is only an estimate of how much my insurance will pay for my treatment and what my out of pocket portion will be. This estimate is based on the type of coverage I have on the date the estimate was given. I understand and agree that should my insurance company fail to pay for any part or all of my treatment I bear full responsibility to pay. In the event that my insurance company pays more than what is estimated, I will be issued a refund by AFD. I also understand that AFD will file with my insurance company as a courtesy to me and that I retain full responsibility to manage my insurance concerns.
5. I understand that all dental procedures have benefits as well as certain risks, including possible side effects from some medicines used in dentistry, and that these risks include, but are not limited to:
    a. Allergic reaction
    b. Cuts/abrasions
    c. Tenderness/bruising from injections
    d. Sensitive teeth
    e. Swallowing or inhaling dental materials or prosthesis
    f. Infections or serious complications or conditions

The staff of AFD will be available to provide answers concerning the risks involved with specific procedures.

By signing below, I am indicating that I understand the terms listed above and/or the legal authority for serving as a legal guardian and consenting to treatment of the patient. I hereby give consent to AFD to perform those tasks, including anesthesia, necessary or appropriate for proper dental examinations, diagnosis, and treatment.

All of my questions regarding this consent agreement have been answered and I can request a copy of this document for my reference.

Signed: _____ Printed: _____ Date: _____

Relationship to Patient (please circle one): Self Parent Guardian

Witness _____ Date: _____