LINCOLN DENTAL

Informed Consent for General Dental Procedures

You, the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of recommended procedure, alternative treatments, and the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all you questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow you dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of this form.

1. Treatment to be provided
I understand that during my course of treatment the the following care may be provided:

Examinations_____Preventative Services_____Restorations_____

Crowns_____Bridges_____Other_____ **Patient Initials_____**

2. Drugs and medications
I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock(severe allergic reaction). **Patient Initials_____**

3. Changes in Treatment
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.
It is Lincoln Dental's policy to provide you with information of procedure and financial changes prior to changing treatment. **Patient Initials_____**

4. I give my permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. **Patient Initials_____**

_____ _____
Patient Signature **Date**

HIPAA ACKNOLDGEMENT

LINCOLN DENTAL

129 Lincoln Street
Worcester, MA 01605
508-754-5891

Patient Name: _____

Date of Birth: _____

I have received and understand this Practice's Notice of Privacy Policy written in plain language. The notice provides in detail the uses and disclosures of m y protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Policy, and to make changes regarding protected Health Information resident at, or controlled by this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Policy upon request.

Signature: _____

Date: _____

Relationship to patient if signed by a Parent or Legal Guardian:

_____