Consent to Proceed

- I authorize Dr. Jon C. Fairbanks and/or such associate or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide:, analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.
- I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.
- I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth ay remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.
- I understand that as part of dental treatment items including, but not limited to: crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.
- I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.
- I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Office Philosophy

- We strive for excellence in every aspect of your dental care, and we will always do our best.
- We respect your appointed time, and make every effort to stay on schedule ourselves.
- Since we rarely are late, please understand if we are delayed because of an unusual dental emergency.
- If you have and emergency dental problem, you will be seen that same day you call.
- When treating a minor we require the parent/guardian to be in the office during time of service.

Financial Policy

Payment is due on the day services are rendered unless prior financial arrangements have been made. We will submit your dental insurance claims at no charge and we expect you to pay your portion of the bill on the day of service. If insurance reimbursement is not received, you will be billed for the balance due. For treatment plans that require a large financial investment in your dental health, feel free to discuss with us the payment plans we have available.

All delinquent accounts will be charged an interest rate of 1.5% per month *(18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee equal to 4-0% of the unpaid balance. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees.

Patient Name: _____

Signature: _____ Date: _____
(Patient, legal guardian or authorized agent of patient)

Witness: _____ Date: _____