Marina Bay DENTAL ASSOCIATES

308 Victory Road
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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 the recommended procedure, alternative treatments, or 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 of your 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 your 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 the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:
Examinations, Preventative Services, Restorations, Crowns, Bridges, Other

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or severe allergic reactions.

3. Changes in Treatment Plan

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.

4. Insurance and Payments

I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.
I, the patient, will be financially responsible for all balances not paid by insurance.

Patient Name: _____Date: _____
Patient Signature: _____Date: _____

HIPAA POLICY and RELEASE OF INFORMATION

Please be advised that Marina Bay Dental Associates operates in accordance with the Health Insurance Portability and Accountability Act. As such, your protected health information may be used and disclosed by your dentist, the staff, and others outside this office who is involved in your care and treatment for the purpose of providing health care services, to pay your bill, to support the operation of the dental practice, and any other use required by law. You have the right to review and request changes to your health information. You may also request restrictions on the use of your health information. The provider must agree to any amendments to your record or restrictions in the use of your information. If the request is denied, you have the right to file a formal complaint with the Secretary of Health and Human Services.

Patient Name: _____Date: _____
Patient Signature: _____Date: _____