156 State Street
4th Floor
Boston, MA 02109
Tel. (617) 725-0515
boston-smiles.com

Advanced Cosmetic & Implant Dentistry

Malek Esrawi, DMD, FICOI, DICOI.

197 Barnstable Road
Hyannis, MA 02601
Tel. (508) 771-4044
Fax (508) 771-0922
capecodsmiles.com

Informed Consent for General Dental Procedures

Name:_____

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 until you discuss potential benefits, risks, and complications with your dentist and all 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 op 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.

1. Treatment to be provided:

I understand that during the course of my treatment that the following care may be provided:

Examinations_____ Preventive 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 tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

PATIENT INITIALS_____

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 teeth that were not discovered during an examination, the most common being root canal therapy following routine restorative procedures. I give my permission to Dr Esrawi to make any/all changes and additions necessary as long as I am aware.

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

5. I give permission to communicate with the office via emails regarding my treatment.

PATIENT INITIALS_____

6. I give permission to use my intraoral or extraoral photos for training and marketing: Yes☐ No☐

PATIENT INITIALS_____

Patient Signature_____ **Date**____/_____/_____