DENTAL SURGEONS & IMPLANT CENTERS
OF FALL RIVER AND DARTMOUTH

GENERAL OFFICE CONSENT FORM

This is a general consent that you agree to be seen in our office for evaluation, consultation, x-rays as needed, treatment planning, and possible treatment.

You, the patient have the right to accept or reject treatment recommended by the doctor. 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.

By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.
As with all treatment, there are commonly known risks and potential complications associated with treatment. **You will be given more specific informed consents verbally and in writing regarding specific procedures as they apply to you.**

It is very important that you provide accurate information before, during and after treatment. It is equally important that you follow the 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 you may increase the chances of poor outcome.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you it is important to report any problems or complications you experience so they can be addressed.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if you are prescribed, or if you are taking antibiotics.

Do not sign this form or agree to treatment until you have **read, understand, and accept** each paragraph stated above. If you do not have enough proficiency in English to read and understand this form, please tell us. Please discuss potential benefits, risks and complications of recommended treatment with the surgeon. Be certain all of your concerns have been addressed to your satisfaction before commencing treatment.

This form also serves as consent that you agree to pay for any services or treatment rendered that are not covered by your insurance providers, including consultations, x-rays, and procedures.

______________________________________ __________________

Patient, Parent or Guardian Signature Date

⧫ Fall River, MA 508-672-1069 ⧫ North Dartmouth, MA 508-992-0339

www.dentalsurgeonsma.com