CONSENT FOR DENTAL TREATMENT

I hereby authorize Dr. Johnson to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Johnson to make a thorough diagnosis of my dental needs. I also authorize Dr. Johnson to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand that dental treatment and the use of dental anesthetics embodies a certain risk including, but not limited to:

1. Postoperative discomfort that may require several days of home care.
2. Injury or damage to adjacent teeth or restorations.
3. Postoperative infection that may require additional treatment.
4. Stretching of the corners of the mouth that may cause cracking and bruising And may heal slowly.
5. Allergic reactions (previously unknown) to any of the medications used during the course of treatment.

I understand that there is no warranty or guarantee made regarding any result and/or cure. I also understand that I can ask any questions regarding my care including a detailed explanation of the risks versus benefits of the proposed treatment.

I understand that my dental insurance is a contract between the insurance carrier, and me and not between the insurance carrier and Dr. Johnson and that I am still fully responsible for all dental fees. These fees are due and payable via cash, check, credit card (VISA, MasterCard, or Discover), or CareCredit* at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to Dr. Johnson. Any payments received by Dr. Johnson from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I understand that insurance pays on a "UCR fee schedule" which is not necessarily this office's fee schedule, and that the insurance difference quoted is only an estimate. Therefore, any difference between what has been quoted and actually paid by my insurance carrier is my responsibility. I understand that all fees quoted will be valid for three months from the date of my treatment plan. I further understand that a late charge will be added to any overdue balance and that a service charge will be added to any returned check.

I hereby provide my consent for routine disclosure of my pertinent health records for processing my dental insurance claims (if applicable) or for the purpose of consultation with other healthcare providers/specialists as it pertains to my treatment.

I hereby certify that I have read and understand the above, that I have been presented with a written treatment plan and fee estimation, and give my consent to treatment in the office of Dr. Johnson.

Patient's Signature: _____Date: _____

Doctor's Signature: _____Date: _____

*CareCredit is a dental charge account that allows the patient to complete their dental treatment and spread the payments out over time. The first three months are without any interest. If you have an interest is this charge account please ask for further information and an application.