Comfort Dental of Lafayette, P.C.

Please read and sign the following:

DENTAL CONSENT

- I have come to Comfort Dental of Lafayette, P.C. for dental diagnosis and treatment.
- Proposed treatment has been/will be explained to me and I choose to proceed with the prescribed treatment.
- I realize that there are risks associated with dental treatment which include, but are not limited to:
    1. Allergic reactions from local anesthetics, medicated rinses, latex gloves, prescription medication, or other products used in the treatment of dental conditions.
    2. Trauma to adjacent oral structure, such as teeth, gums, tongue, cheek, lip, or face.
    3. Irreversible pulpitis, necessitating root canal therapy or extraction, due to extent or depth of decay and/or the amount of tooth surface prepared as prescribed for treatment of tooth.
    4. Permanent or temporary numbness associated with the administration of local anesthetic, extraction of teeth, root canal therapy, infection, or other oral surgical procedures.
    5. Pain or discomfort associated with the TMJ or jaw joint.
    6. Elevated tooth sensitivity to hot, cold, sweet, pressure, air, and chewing or biting.
    7. Aspirating (breathing in) or swallowing dental instruments, dental products, or tooth structures.
    8. Breakage of dental instruments such as root canal files, dental burs, or dental hand instruments.
- I understand that should any of these risks occur during or as a result of my dental treatment, the dentist may refer me to a specialist or medical doctor for further treatment of my dental condition and/or any treatment required due to the associated risk.
- I also understand that the dentist may need to change my proposed treatment plan during or after actual treatment. The dentist/dental staff will inform me of the need to change and will convey any change in cost to myself or my insurance company prior to performing additional treatment.
- I agree to hold harmless Comfort Dental of Lafayette, P.C. and all associated dentist and staff in the unfortunate event that any risk, side effect, symptom, post operative pain, or loss of tooth/teeth should occur during or after dental treatment.
- This document will be on file at the dental office and will be applicable to any and all dental treatment during and after patient's treatment at Comfort Dental of Lafayette, P.C.

I agree to the above statements and give my consent for treatment for my child or myself.

CANCELLATION POLICY

Due to the increasing number of patients seeking dental care, it is important that you keep you scheduled appointment. In an effort to better serve our patients we **require a 24-hour cancellation notice** should you wish to cancel your appointment. In the event that you fail to notify the office of the cancellation two times, it **will result in no new appointments being scheduled for you.**

PAYMENT OPTIONS

- We accept VISA/Mastercard/Discover
- Personal checks and cash
- We also have special outside financing available

INSURANCE POLICY

As a courtesy, we will bill your insurance company for covered charges. In order to bill your insurance, you will need to provide us with the necessary accurate and complete information. Remember that your insurance policy is a contract between you and your insurance company and you are responsible for all charges incurred. You will be responsible for paying your percentage after insurance at the time service is rendered. We expect insurance payments within 45 days from the date of service. If your insurance has not paid and the account becomes 60 days old, the account may become a cash account and may be due and payable at that time.

I hereby guarantee payment of all charges incurred for the account above mentioned. I realized that insurance may not cover the amount charged and that I am responsible for the balance left after insurance. In the event that no insurance is being filed, payment is due at the time services are rendered.

I have read and understand the above Consent for Treatment, Cancellation Policy, Payment Options, and Insurance Policy.

Patient Name: _____ **Date:** _____

Guardian Name: _____