

**Zoe Collier D.D.S.**  
**Dental Treatment and General Consent Form**

**1. Health Information:**

I agree to disclose all previous illness and medical history. Undisclosed medical information, current medication, allergies or illness are risk factors.

**2. Drugs, Latex and Medicines:**

I understand that antibiotics and other medications can cause allergic reactions and even life-threatening anaphylaxis. Also, some antibiotics can interfere with birth-control pills. Latex allergies can cause rashes and itching. Epinephrine increases heart beat and, depending on my health, may be dangerous to me.

**3. Needle Stick:**

If someone is inadvertently stuck with a needle used on me, I consent to have blood drawn for analysis.

**4. Fillings, Crowns and Un-Anticipated Root Canals:**

Some teeth may need a Root Canal even after a simple filling. Fillings and Crowns do take away tooth structure and a percentage of these teeth end up needing a root canal after the filling or crown is done.

**5. Root Canals can Fail:**

Root Canals can fail and may require additional treatment or I may end up having the tooth extracted.

**6. Porcelain Crowns, Veneers, Bonding and Cosmetic Fillings:**

Porcelain Crowns, Veneers, Cosmetic Bonding and Composite Fillings are esthetically pleasing; However, I understand that if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, bonding of fillings are placed, I Understand that the color cannot be changed.

**7. Gum Treatment and Requesting "Just a Cleaning":**

If I don't floss or if I smoke, I can expect to have deteriorating gum conditions. I agree that if I need gum treatment, I will not insist that I simply get a cleaning.

**8. Extractions and Surgery:**

I understand that all dental extractions or surgeries care a risk. Some are minor like dry socket and some are life-threatening such as post surgical infections or anaphylaxis.

**9. Fee for Additional or Specialty Care:**

I understand that I may need treatment beyond what was originally planned (a crowned tooth becomes painful and will need a root canal), or I may be referred to a specialist for additional care . I agree to be financially responsible for the additional or specialty care.

**10. Limitations of Insurance Coverage:**

There are charges beyond what insurance will pay, Example (nitrous oxide, temporary dentures, bleaching, or cosmetic work). Also, as a service to patients, this office will file insurance claims on their behalf. I understand that what may be quoted as my portion (Co-payment) is only an estimate. I agree to be financially responsible for what the insurance does not cover.

**11. Requesting Record Transfers:**

Professional courtesies are between dentists. I agree not to request records until I have a new dentist. The records will be only transferred to another Dental Professional, and account must be paid in full before any records will be transferred. Our office will retain the original xrays.

**12. Appointments:**

If I am more than 15 minutes late for my appointment, I will take my remaining time only, or reschedule. Understand that we may not be able to accomplish everything scheduled for that appointment. If you NO SHOW or Cancel your appointment under 24 hours, our office has the right to charge you a late fee of \$75.00.

**13. Check Writing Policies:**

We will accept Personal Checks, to do so you must have a credit card on file with our office. You agree that if a check is returned to our office for NSF or another reason we have the right to charge your card for the amount of the returned check and our fee for returned checks which is \$30.00. We will contact you prior to charging your credit card.

I do not expect guarantees in dental care. I have read the above and consent to treatment.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

