Holly Tree Dental
Robin Feltoon
171 Rockland Street
Hanover MA 02339
(781)826-8331

Informed Consent for General Dental Procedures

Patient Name:* ______ * ______ ______ ______
Last First MI Preferred Name

You, the patient, have the right to accept or reject dental treatment recommended by your dentist/dental hygienist. 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 unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions have been 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/dental hygienist with accurate information before, during and after treatment. It is equally important that you follow your dentist's/dental hygienist's 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 of your dentist, you may increase the chances of a poor outcome.

Please read and check the items listed below and sign at the bottom of the form.

1. Treatment to be provided:

I understand that during the course of my treatment that the following care may be provided:
Examinations * Diagnostic Services * Preventative Services * Restorations * Local Anesthesia * Periodontal Services * Other

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). It is my responsibility to report any of these occurrences and immediately and report to the nearest emergency room for further evaluation.

3. Changes in Treatment Plan:

I understand that during the treatment it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

4. Financial and Insurance:

I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered or as outlined in a signed financial arrangement. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

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I understand that account balances over 60 days will be subject to 18% annual finance charge.

We require a minimum of 24 hours notice to cancel or reschedule an appointment.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carryout payment activities in connection with my claims.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the dentist or dental entity.

This general informed consent will remain in effect until treatment is terminated either by the dentist and/or the patient and the patient is not longer regarded as a patient of record.

Response Date: __________