Consent for Adult X-Rays and Oral Evaluation

Dental Zone

Patient Name _____ Date of Birth _____

It is your right, as a patient, to understand the risks, benefits, and alternatives of your dental treatment, and to accept or refuse treatment offered to you.

Please read this form carefully and ask about anything you do not understand.

EXAM

Every patient is a unique individual thus not every require will require the same treatment to obtain a comprehensive oral examination. Based upon you age, teeth present, and tooth position, Dr. ********** will determine if radiographs (x- rays) are necessary. In general, the examination appointment also includes cleaning of the teeth and application of topical fluoride/ fluoride varnish.

TREATMENT

If you should need any dental treatment after the dental examination has been completed, Dr. ********** will review the planned treatment with you. Please read the following information regarding dental treatment at our office.

- It is our policy that all treatment options are explained to the patient(s), including treatment alternatives, advantages, and disadvantages of each. Although good results are expected, it is not possible to guarantee success due to the possibility of complications.
- Risks that are occasionally associated with dental treatment procedures include: numbness, swelling, bleeding, soreness, tooth discoloration, nausea, vomiting, hyperventilation, fainting, allergic reactions and infection. On rare occasions complications may arise that require hospitalization.

With my signature I authorize a Dental Zone or employee to expose x-rays for diagnostic purposes and perform a dental exam and I acknowledge that I have reviewed the possible risks and complication associated with dental examination and x-rays.

_____	_____
Parent / Guardian Printed Name	Relationship to Patient
_____	_____
Parent/ Guardian Signature	Date
_____	_____
Witness Printed Name	Witness Signature