DAG ZAPATERO, D.D.S., M.A.G.D.

General | Cosmetic | Restorative | Implant | Geriatric Dental Care

INFORMED CONSENT FOR DENTAL TREATMENT

I, _____, consent to be a patient of this office and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. I authorize Dr. Dag Zapatero, or his designated team members, to acquire diagnostic information (radiographs, dental casts, charting, periodontal probing, photographs, and any other tests deemed appropriate) in order to make a thorough diagnosis of my, or my dependent's, dental needs.

2. Upon diagnosis, I authorize Dr. Zapatero to perform all recommended treatment that is mutually agreed upon and to employ such assistance as required to provide proper care. I understand that my treatment plan may change due to factors not evident during the initial treatment planning phase.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I agree to the use of local dental anesthetics during the course of my treatment. I understand that the use of anesthetic agents carries certain risks, including (but not limited to) temporary or permanent numbness (paresthesia), rapid heartbeat, allergic reaction, or fainting. I understand that I may ask for a complete description of any possible complications at any time.

5. I will provide a thorough and complete medical history, including a full list of my medications with dosages, and I consent to my dentist communicating with my other medical practitioners regarding any aspect of my health history when necessary care.

6. I am welcome to ask questions about any aspect of my dental care and will request additional information if I am confused or need clarification. I am responsible for clarifying any aspects of my treatment that I do not fully understand.

I have had the opportunity to ask questions and am satisfied with the information provided.

_____ _____

Patient or Legal Guardian Signature Date

_____

Printed Name of Patient or Legal Guardian

_____ _____

Witness Signature Date