



(626) 351-8444
482 N ROSEMEAD BLVD, STE 201
PASADENA, CA 91107

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
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 will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover. Any unpaid balance will have a 1% service charge per month (18% per anum) on the unpaid balance after 60 days.
5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.
6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.
7. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.
8. Emergency dental services or dental services without previous financial arrangements, must be paid in full at the time services are performed unless other arrangements are made
9. The Dental Materials Fact Sheet, required by the State of California, has been made available for me to review.

I have read the above statement and agree to their content

Patient or Guardian Signature

Date