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

1. I hereby authorize Dr. Dag Zapatero, or his designated team member to acquire diagnostic information (radiographs, dental cast, charting, periodontal probing, photographs), and other test deemed appropriate to make a thorough diagnosis of my/my dependent's dental needs.

2. Upon diagnosis, I authorize Dr Zapatero, to preform all recommended treatment mutually agreed upon and employ such assistance as required to provide proper care. I also understand that my treatment plan may change due to factors not evident during the treatment planing 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 dental anesthetics during the course of my treatment. I fully understand that the use of anesthetics agents embodies certain risk (tachycardia, paresthesia both reversible and irreversible numbness, and fainting), however small. I also understand that I can ask for a complete description of any possible complication.

5. 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.

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.

_____ _____

Patient or Guardian Name Date

_____ _____

Witness Date