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

General | Cosmetic | Restorative | Implant | Geriatric Dental Care

Informed Consent for Dental Treatment

I, _____, consents to allow treatment of dental conditions by the office of Dr. Dag Zapatero, and understand that a complete clinical and radiographic examination will be conducted.

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.

7. If this account is referred to an attorney for collection then the undersign person(s) promise and agree to pay all collection costs including attorney fees of 33 ⅓% of the principal amount due and owing when turned over for collection and do further agree to pay interest of 1 ½% per month (18% per Annum) on the unpaid balance from the date the services were last rendered. In the event this matter is turned over for collections, I hereby expressly give permission for my current employer(s) to provide verification of my said employment to this office, or attorney, Tiffany & Tiffany, P.L.L.C.

_____ _____

Patient or Guardian Name Date

_____ _____

Witness Date