



CONSENT FOR DENTAL EXAMINATION

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

- During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, fixed and removable prosthodontics (crowns, bridges, veneers, dentures, partials), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology and radiography.
- I will provide a thorough and complete medical history, supply a full list of my medications to include dosages, and consent to Dr. Schmitt/Dr. Ramos to communicate with my other medical and dental practitioners to inquire about any aspect of my health history.
- 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.
- I will pay in full any cost of treatment according to the office's financial policy. I understand that the office does not participate in, contract with, or in any way work with dental insurance. If I choose to file a claim for reimbursement, this process will be my responsibility.
- My treatment plan may change at any time, if Dr. Schmitt/Dr. Ramos deem it necessary and in my best interest to achieve optimal health results. If changes are necessary, Dr. Schmitt/Dr. Ramos will have a discussion with me and answer any and all questions I may have.
- If I have any questions or concerns about any aspect of my dental care, if I feel confused or need more information, it is my responsibility to ask for clarification for any treatment that I have questions about.

PATIENT'S SIGNATURE: _____ **DATE:** _____

STAFF SIGNATURE: _____ **DATE:** _____