ONE DENTAL CARE, PC.
655 BOSTON ROAD, UNIT 3A,
BILLERICA, MA 01821
(978) 667-0691 INFO@ONEDENTALCARE.COM

I, _____, consent to be a patient at the above named office and agree to a comprehensive examination with radiographic examination, oral cancer screening with VELscope and intra-oral/extra-oral hard/soft tissue 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, are not exact science and 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.

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 welcomed 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. **Appointments and Cancellations -** When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 48 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it. **There is a charge for not showing up for scheduled appointments.** ***Repeated cancellations or missed appointments will result in loss of future appointment privileges.*** We feel that our patient's time is valuable. When your appointment is

made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

8. All paperwork that require patient's signature will be either signed electronically on a tablet computer, signature pad, using digital signature files or will be scanned after signing on a paper version of the form.

_____ _____

Patient or Guardian Signature Date

_____

Name of Patient or Guardian

_____ _____

Witness Signature Date

_____

Name of Witness