Adam Vaghari DDS
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Informed Consent General Dentistry

1. **Examinations, Xrays, Imaging:**
   I understand that the initial visit may require radiographs and imaging in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as described in the attached treatment plan. **(Initials_____)**

   Dental Prophylaxis (Cleaning)
   I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal gum disease. **(Initials_____)**

2. **Electronic Storing of Documents/Photographs:**
   I understand and agree that it is our office policy to scan original documents and store the documents in electronic form into our patient's charts. **(Initials_____)**

   I grant to *Adam Vaghari DDS* and employees the right to take photographs of me (face, mouth, teeth) and to use such photographs of me, with or without my name, for any lawful purpose, including: publicity, illustration, advertising and web content. **(Initials_____)**

3. **Changes in Treatment Plan:**
   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. **(Initials_____)**

4. **Dental Benefits:**
   I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance is a courtesy and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment. I also understand that rather than my insurance company, I am responsible for all fees relating to this treatment, including any balances unpaid by my insurance company. **(Initials_____)**

5. **Excessive Failed or Cancelled Appointments:**
   The Dentist's/Hygienist's time is valuable so we ask that you let us know 24 hours in advance if an appointment has to be re-scheduled. We allow for the possibility of (3) failed appointments or appointments cancelled without the 24 hour notice before charges will be accessed. After that, there will be a charge of $50 for each appointment failed or canceled without the 24 hour notice. **(Initials_____)**

6. **Drugs, Medications and Sedation:**
   I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and or other anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. Medications may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills). I understand that all medications have a potential risks, side effects and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking. **(Initials_____)**

I certify that I have read the above and fully understand this consent for treatment

Signature:____ **Date:**____________________________