Family Smile Dental
3029 Ave V
Brooklyn, NY 11229
Tel (718)332-4060 Fax (718)686-0228
1985 Ocean Ave, Suite D-1
Brooklyn, NY 11230
Tel (718)376-4200 Fax (718)376-4202

GENERAL CONSENT

Patient Name:_____ **Birth Date:**_____

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at ***Family Smile Dental***.
These procedures include, but are not limited to: examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk of swelling, bruising, allergic reaction, changes in pain considered in effect until rescinded or revoked.

Print your name and relationship:_____
Signature:_____ **Date:**_____

This section needs to be completed for children under the age of 18 by a parent or legal guardian ONLY.
I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name:_____ Relationship:_____
Name:_____ Relationship:_____

If child is over 13 years old, please check one of the following:
☐ Since my child is over the age of 13, I also give permission for him/her to present for treatment unaccompanied by an adult. I understand that no invasive treatment, such as extractions or the initiation of root canal therapies, will be performed unless I am notified by telephone. In the event of an emergency, when I cannot be reached, I give permission to perform whatever therapies are deemed necessary by the treating provider.
Although my child is over 13, I wish to be present for all treatments performed.
☐ **Signature of parent or legal guardian**:_____

This consent shall be considered in effect until rescinded or revoked

Family Smile Dental
3029 Ave V
Brooklyn, NY 11229
Tel (718)332-4060 Fax (718)686-0228
1985 Ocean Ave, Suite D-1
Brooklyn, NY 11230
Tel (718)376-4200 Fax (718)376-4202

Financial Resposibility

This office is happy to cooperate with individuals who are covered by dental insurance. We only ask that you carefully read your policy to be sure that you are fully aware of any restrictions that apply to the benefits provided. Dental insurance is a contract between the patient and the insurance company for reimbursing the cost of dental services. It is not a contract between the dentist and the insurance company.

I, _____, understand that I am financially responsible for all services rendered by the dentist. I understand any co-payments, deductibles, and/or procedure cost not covered or denied by my insurance company (including coverage termination prior to the date services are rendered), are my responsibility. This dental office is authorized to fill out and/or assist me to complete any and all insurance forms pertaining to services rendered.

_____

Patient Signature (or Parent/Guardian Signature for Patients under 18 years of age) **Date**