ILDERTON
DENTAL CARE

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Dates: YYYY-MM-DD (for example 2026-10-01). Leave anything you'd rather discuss in person; a blank is not a "No".

I authorize the dentist, the practice and qualified staff to…

- perform diagnostic procedures for the purpose of determining my oral health and treatment options.
- perform basic clinical treatments required to restore, maintain or improve my oral health after consultation with me.
- consult with my medical doctor or other health care professional regarding my general or oral health conditions.
- transfer my records to another dentist if necessary or requested.
- exchange information with my insurance provider for the purpose of administering claims.
- provide major clinical treatment to restore, maintain, or improve my oral health after consultation with me or clearly explain my treatment options, prognosis and risk, and only after I have explicitly agreed to proceed the treatment.
- take appropriate and advisable steps in the event of unforeseen conditions, reactions or emergencies that may arise during treatment.

I understand that basic and diagnostic procedures include (but are not limited to):

– periodic check-ups which re-examine the whole mouth.
– any treatment or service which is normally provided by a registered dental hygienist or preventive dental assistant.
– the application of substances and techniques known to be helpful in the prevention of cavities.
– the application of substances or techniques known to be helpful in the minimizing pain and discomfort, such as anaesthesia, or de-sensitization.
– radiographs (x-rays) as required for accurate diagnosis or treatment planning after consultation with me.
– occlusal (bite) adjustment and the fabrication of oral appliances.
– the preparation of teeth and the placement of filling to restore function and aesthetics.
– procedures that preserve and maintain the function and aesthetics of previous restorations.

I understand that…

- all dental procedures have potential complications and risks that cannot always be predicted
- I have the right to ask questions and receive complete answers regarding any procedure
- I have the right to decline or stop treatment at any time
- my choice to decline or stop treatment may adversely affect my dental health condition
- I am financially responsible for all fees incurred during the course of my treatment

Acknowledgements

☐ I have read the General Consent and agree to its statements.

Signing as ○ Patient ○ Parent ○ Guardian

Name

Signing: type your full name below, or print this page and sign by hand. A typed name is not a certified digital signature; you can also sign at the clinic.

Signature

Date (YYYY-MM-DD)