



APPLE DENTAL HEALTH SERVICES, P.C.

113-16 76th Rd. Forest Hills, NY 11376
Toll Free 1-888-83-APPLE (27753)

Dental Health Consent Form

Patient's Name

First Name Last Name Initial Date of Birth

I hereby authorize Dr. and others whom he/she may designate as his/her associates or assistants (collectively "dental team") to perform upon me the following operations and/or procedures:

- | | |
|--|--|
| <input type="checkbox"/> Tooth Filling | <input type="checkbox"/> Crown, Bridges, and Caps |
| <input type="checkbox"/> Tooth Extraction | <input type="checkbox"/> Dentures (Complete or Partial) |
| <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Endodontic Treatment (Root Canal) |

Other

I understand that during the course of the planned operations and/or procedures unanticipated conditions may arise and necessitate procedures in addition to or different from those planned. I authorize the dental team to perform upon me additional and/or different procedures that they may consider necessary.

I consent to the administration of anesthesia, antibiotics and other medications that may be deemed necessary for my treatment. I understand that such medications can cause adverse reactions that include pain, swelling of tissues, dizziness, cardiac arrest, and vomiting.

I will be advised of the purpose and nature of the above treatment, expected results, and material complications and risks that may arise. I will be informed of possible alternatives, including the option of non-treatment, and the consequences of each. I will be given sufficient opportunity to ask questions, and all of my questions will be answered to my satisfaction.

I understand that any surgical procedure can entail certain complications. I recognize that common to oral surgery is the potentials for pain, swelling, bruising, bleeding and allergic reactions. I also realize that other complications can include damage to adjacent teeth or dental restorations, opening of the sinus, infection, jaw fracture, nerve injury, and small root fragments remaining in the jaw that may require addition operations to extract.

I have provided information concerning my physical and mental health as accurately and completely as possible. I agree to cooperate fully with the dental team while I am under their care. I acknowledge that no guarantee have been made to me concerning the results of the operation or procedure. I confirm that I have read and fully understood the content of this form prior to my signing.

Patient or Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

Witness Signature _____ Date _____