Chauvin & Chauvin, D.D.S., P.A.
816 Lower Dallas Highway
Dallas, North Carolina 28034

STANDARD CONSENT FOR DENTAL PROCEDURES

PLEASE READ THIS FORM CAREFULLY

1. I, _____ hereby authorize Dr. Jeffrey Chauvin and Dr. Nancy Chauvin and whomever they may designate as their assistants, to perform upon me any of the following dental treatments or oral surgery procedure(s), with my approval, that have been deemed necessary or advisable, including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids. Advisable treatments could include the following and will be determined by an examination performed by Dr. Jeffrey Chauvin or Dr. Nancy Chauvin:
   A. Preventive hygiene treatment, (prophylaxis) and the application of topical fluoride.
   B. Application of plastic "sealants" to the grooves of the teeth.
   C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
   D. Replacement of missing teeth with dental prostheses, (bridges and partial dentures).
   E. Removal (extraction) of one or more teeth.
   F. Treatment of diseased or injured oral tissues (hard and/or soft).
   G. Use of sedative drugs to control apprehension and/or disruptive behavior.
   H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

   You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

2. I further consent to the administration of local anesthesia, antibiotics, analgesics or any other drug that may be deemed necessary for dental treatment, and I understand that there is an element of risk inherent in the administration of any drug or anesthesia. These risks includes adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration, pain, discoloration and injury to blood vessels and nerves which may be caused by injections or any medications or drugs. I understand these risks and hereby acknowledge that I will have an opportunity to ask questions regarding the treatment and the risks.
3. I will be advised that the success of the dental treatment to be provided will require that the patient and/ or parents of the patient follow post-operative and post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed along with regular office visits as scheduled by my dentist.
4. I am aware that the practice of dentistry is not an exact science and that unknown conditions found may change the treatment recommendations. I understand that I will be informed of any changes to my dental procedure(s) at the realized convenience. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being, in the professional judgment of the dentist. I acknowledge that no guarantees have been made to me concerning the results of the dental procedure(s) being performed.

5. I consent to photographs being taken. I understand the doctors will use the photographs, radiographs, other diagnostic materials and treatments records for illustration and for documentation of my treatment.
6. I have provided an accurate and complete medical and personal history as possible, including those antibiotics, drugs and foods to which I am allergic. I will follow any/all instructions during, and after my dental procedure(s) as it is explained to me and I agree to report any unanticipated reactions to Chauvin and Chauvin, D.D.S., P.A. as soon as possible. I will be given the opportunity to ask questions about my dental procedure(s) and responsive explanations will be given to me. I understand that additional appointments may be required and I agree to the terms of the cancellation policy. I understand that I may be charged a fee if I fail to inform the office at least 24 hours in advance of any reserved appointment that I may cancel.
7. I understand that Chauvin and Chauvin, D.D.S., P.A. will file my insurance claims as a courtesy for me and I agree to pay any balance or copay at the time of service. If there is any additional balance remaining after insurance payments are received, I agree to pay the remaining balance in full within 30 days. If my insurance company sends payment to me directly I understand that I may be asked to pay my balance in full. I understand that other financial arrangements must be made prior to scheduling an appointment associated with the treatment recommendations and I agree to be responsible for the full payment of the dental procedure(s) rendered. I understand that a .66% finance charge per month (8.0 percent annually) may be added to my account for any balance over 90 days, regardless of any pending insurance claims. I understand that I am responsible for any fees/costs that may be incurred for the collections of my account (e.g. collection agency fees, courts, and attorney fees).
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatments.
9. I further understand that the consent will remain in effect until such time that I choose to terminate it.

Date:_____ Time:_____

Patient's Name:_____

Name of Parent or Personal Representative:_____

Relationship to Patient:_____

_____

Signature: Patient or Parent or Personal Representative