PELLEGRINI DENTAL
INFORMED CONSENT GENERAL DENTAL PROCEDURES

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.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentist or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of this form.

1. Treatment to be Provided

I understand that my course of treatment, may involve the following procedures:

- examinations
- preventative services
- fillings
- crowns
- bridges
- implants
- extractions
- root canals
- dentures

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Patient Initials

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

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Patient Initials

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of unforeseen conditions revealed while working on the teeth. I give my permission for Dr. Dave and/or Dr. Pete to use his professional judgment and perform such additional procedures that are desirable to complete the procedure at hand.

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Patient Initials

4. I give my permission to Pellegrini Dental to bill my dental insurance provider for the treatment provided, if applicable.

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Patient Initials

5. I understand that Pellegrini Dental will make every effort to assist me in collecting from my insurance carrier, but, that ultimately, I am responsible for the cost of my dental treatment. After 60 days, any outstanding balance will be paid by me, even if payment is expected from my insurance carrier. Pellegrini Family Dentistry will continue to help me collect from my insurance carrier and guide me and maximize my benefits.

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Patient Initials

Patient Signature Date