RICARDO C.GUILLEN, D.D.S.,P.L.L.C

INFORMED CONSENT FOR DENTAL TREATMENT- PROPHYLAXIS

PATIENT NAME _____ **DATE** _____

PLEASE CIRCLE YOUR CHOICE FOR TODAY'S APPOINTMENT:

RADIOGRAPHS AND PHOTOGRAPHS

I understand that Ricardo C. Guillen D.D.S.,P.L.L.C. will take necessary radiographs, photos, and other diagnostic aids as needed to make a thorough diagnosis and provide treatment. I understand that photos and radiographs will be sent to other providers and insurance companies if required. I understand that Dr. Guillen will keep these records confidential unless I give written permission to use them for the purpose of research or education. PLEASE CIRCLE TO CONSENT OR REFUSE

I **CONSENT** **REFUSE** to have recommended radiographs, photos, and other diagnostic aids.

PROPHYLAXIS (dental cleaning)

I understand that a professional dental cleaning is a required component of a healthy oral hygiene regimen. I consent to have the hygienist use special instruments to clean my teeth, including scraping below the gum line removing plaque and tarter that can cause gum disease, cavities, and other problems. I realize that I may experience jaw discomfort, sensitivity, tenderness, and bleeding of the gums during or after my dental cleaning. PLEASE CIRCLE TO CONSENT OR REFUSE

I **CONSENT** **REFUSE** to have the recommended treatment.

FLUORIDE RINSE

I understand that a fluoride application is to aid in the protection against dental caries. I realize that the following adverse reactions (although temporary) are possible in individuals hypersensitive to fluoride: eczema, upset stomach, headache, and/or weakness. PLEASE CIRCLE TO CONSENT OR REFUSE

I **CONSENT** **REFUSE** to have the recommended treatment.

EXAMINATION

I understand that it is required to see a dentist at least once a year for a complete oral examination. I realize that if I refuse to allow an examination by the dentist, existing conditions that may be detrimental to my dental and physical health may go undiscovered and undiagnosed, and that I am responsible for the consequences. PLEASE CIRCLE TO CONSENT OR REFUSE

I **CONSENT** **REFUSE** to have an examination by the dentist.

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Signature of Patient, Parent, Guardian or Personal Representative Date