Houston (713) 347-6833
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MOBILE DENTAL ASSOCIATES

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CONSENT FOR FIRST DENTAL VISIT

Patient Name: _____ ___ _____ _____ _____
First M.I. Last Nickname DOB

TREATMENT DESCRIPTION All patients must read & acknowledge items 1-5 for the first visit	PATIENT OR RESPONSIBLE PARTY'S INITIALS
1) EXAMINATIONS AND X-RAYS I understand that the initial visit will likely require radiographs(X-Rays), intra-oral photographs, and in some cases digital scans in order to complete the examination, diagnosis and treatment plan. I understand & consent to the diagnostic treatment to be performed as deemed appropriate by the Dentist.	
2) DENTAL PROPHYLAXIS (CLEANING) I understand that this treatment is preventative in nature, is intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.	
3) TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD) I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.	
4) DRUGS, MEDICATION AND SEDATION I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking.	

CONSENT & ACKNOWLEDGEMENT: I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment.

_____ _____ _____
Signature Please Print Signer's Name Date

Signer's relationship to patient? ☐ Patient(self) ☐ Responsible Party ☐ Guardian ☐ Power of Attorney ☐ Conservator