Highlands Dental

2201 W. Wildcat Reserve Parkway Unit C-6
Highlands Ranch, CO 80129
303-220-1122
myhighlandsdental.com

General Consent

I,_____consent to be a patient at Highlands Dental and agree to a radiographic and clinical examination. I also understand the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canal treatment), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
2. I authorize Dr. Burger to prescribe and/or administer any drugs, medicaments, antibiotics, and local anesthetics necessary or appropriate in my care.
3. I will provide a thorough and complete medical history, supply a full list of my medications with dosages and consent to Dr. Burger communicating with my other medical practitioners to inquire about any aspect of my health history.
4. No guarantees can be made about treatment outcomes, restoration longevity or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
5. I will pay in full my cost of treatment or insurance co payment according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am ultimately responsible for any and all fees. Although the office will try to best estimate how my insurance company will pay, each plan is different and it is possible that insurance companies will not pay as expected or not pay at all, thereby leaving myself with a balance that will need to be paid in full.
6. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with the dental staff.
7. I am welcome to ask questions about any aspect of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspect of my treatment that I am unsure about.

_____

Patient or Legal Guardian Signature Date

_____

Witness (Highlands Dental Staff) Date