



Cherry Hills  
Dental Associates, P.C.

FAMILY COSMETIC AND  
IMPLANT DENTISTRY

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## GENERAL DENTISTRY INFORMED CONSENT

1. **DENTAL TREATMENT:** I understand that I may have any of the following dental treatment done which include but are not limited to: fillings, bridges, crowns, extractions, root canals, dentures, x-rays, cleanings, scaling and root planings, implant restorations, etc.
2. **MEDICATIONS AND PRESCRIPTIONS:** I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphalactic shock. In very rare instances, analgesia can cause parasthesia or even permanent anesthesia.
3. **CHANGES IN TREATMENT PLAN:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth which were not discovered during the examination, i.e. root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.
4. **DENTAL INSURANCE:** I understand that it is my responsibility to have the correct insurance information. I understand that I need to inform Cherry Hills Dental of any changes to my insurance. I understand that Cherry Hills Dental will submit claims as a *courtesy* to me, again provided that I give the complete information necessary for these claims. I agree to pay my co-payment on the day of service. I understand that it is "I" who has the contract with the insurance company and Cherry hills Dental merely submits treatment done. I understand that I may have treatment pre-authorized.
5. 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 which I have requested and authorized.

I hereby authorize any of the doctors and dental auxiliaries to proceed and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation. I understand that this contract is to verify that I want treatment done at Cherry Hills Dental and it is not limited to only what was stated previously.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Guardian if minor \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_