Patient Name: ___________________________________ Date: _______________

Please initial by each bullet.

__________ • This is to certify that I the undersigned consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable including the use of local anesthetic as indicated and will assume responsibility for fees associated with those procedures.

__________ • I hereby authorize payment directly to Stockton Family & Cosmetic Dentistry, of the group insurance benefits otherwise payable to me.

__________ • I hereby authorize the release of information relative to this claim to the S.C. Department of Social Services and their assigns. (Medicaid patients only)

__________ • 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 (serve allergic reaction). I have informed the Dentist of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

__________ • I hereby authorize Stockton Family & Cosmetic Dentistry to examine my teeth, mouth, neck, clean my teeth and apply fluoride, and to take the necessary radiographs (x-rays) of the teeth and jaws for diagnosis of my dental condition. The most common complications associated with dental treatment include nausea following the application of topical fluoride, if swallowed. For patients with heart disease the risk of subacute bacterial endocarditis (heart infection) following dental treatment exists; therefore antibiotics will be prescribed before the treatment to minimize the risk. Exposure to x-rays can be damaging to an unborn child. Pregnant women should notify if they are pregnant.

__________ • I understand that during treatment it may be necessary to change and/or add procedure because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

__________ • I understand that oftentimes patients are shown "before and after" photographs of procedures that were completed at Stockton Family & Cosmetic Dentistry via intraoral/extra oral technology. I understand that photographs may be used for in-office use and other educational purposes. I understand that my face will not be present in these photographs unless I sign a written release form.

__________ • I hereby give permission for Stockton Family & Cosmetic Dentistry to contact me via email concerning appointment dates/times as deemed necessary for confirmation and contact purposes. I understand that my email address is strictly confidential and will not be given out to third parties.

__________ • I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction. I also understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I make known that I choose to terminate it.

Patient/Legal Guardian Signature: ____

5219 Two Notch Rd. Columbia, SC 2920
Phone: (803) 735-9446 | Fax: (803) 735-9813 | Email: stocktondentistry@hotmail.com