8001 Wisconsin Ave, Suite 103
Bethesda, MD 20814
Office: (301) 312-8210
Fax: (301) 312-8572

INFORMED CONSENT

By signing this document, I give consent for myself/my child to receive dental treatment deemed necessary by the providers Divine Smiles Dentistry. These procedures include, but are not limited to: examinations, radiographs (x-rays), oral prophylaxes (cleanings), fluoride treatments, and sealants. This consent shall be considered in effect until rescinded or revoked in writing.

X-rays are used to help us with proper diagnosis and allow us to provide the best possible dental care. We may need combinations of panoramic, bitewing, periapical, or occlusal x-rays to maximize our ability to diagnose conditions underneath structures in the mouth. With use of lead shield, dental x-rays provide minimal radiation exposure and provide valuable information necessary for your health. Use of x-rays will help to identify following conditions: periodontitis, abscess, cyst, abnormal anatomy, impacted teeth, extra teeth, resorption of bone, resorption of teeth , fractured teeth, fractured bone, TMJ joint disorder, missing teeth , abnormal growth that can be benign or malignant. The benefit we receive from x-rays far outweighs the minimal risk associated with it. However, you have the option to refuse x-rays and allow us to perform a limited examination visually.

Please mark your choice.

________ **Yes,** I agree and accept x-rays for proper diagnosis.

________ **No**, I voluntarily refuse to get x-rays. I understand that this is against medical advice and will significantly hinder the doctor from properly diagnosing conditions I may have. I will not hold the doctor or the practice liable for any failure to diagnose or improper treatment choices that directly results due to lack of x-ray information.

PATIENT'S AUTHORIZED REPRESENTATIVE
(This section needs to be completed for children <u>under the age of 18</u> by a parent or legal guardian ONLY.)

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments.

Name: ____

Relationship: Mother Father Grandmother Grandfather Aunt Uncle Legal Guardian

Name: ____

Relationship: Mother Father Grandmother Grandfather Aunt Uncle Legal Guardian

○ Since my child is over the age of 13, I also give permission for him/her to be present for treatment unaccompanied by an adult. I understand that no invasive treatment, such as extractions or the initiation of root canal therapies will be performed unless I am notified by telephone. In the event of an emergency, when I cannot be reached, I give permission to perform whatever therapies are deemed necessary by the treating provider.

○ Although my child is over 13, I wish to be present for all treatments performed.

This consent shall be considered in effect until rescinded or revoked.

Patient Name (Print): ____ **Date:** ______________________________

Patient/Guardian Signature: ____

(1.6.16 FC)