Regency Dental

Dr. Donna T. Burton, DDS

Office: (707) 453-1776

1001 Nut Tree Road, Suite 230
Vacaville, Ca 95687

Patient Consent

I hereby authorize Regency Dental, Dr. Donna Burton, and whomever they may designate as their associates, hygienists and assistants, to perform upon _____, all necessary procedures and administer anesthetics, analgesics, and authorized them to do whatever they deem advisable and or necessary as a result of unforeseen circumstances.

The nature, purpose, and risk of the procedures and possible alternative methods of treatment will or have been fully explained to me. I understand that there is a possibility of complications developing during or after any type of dental treatment. These include, but are not limited to, pain, numbness, tooth and soft tissue sensitivity, decimalization or teeth, infection which may require antibiotics, tissue recession, cuts or injuries to the soft tissue which include lips, gums, cheeks, and tongue, fracture of teeth, damage to a healthy tooth, allergic reactions to materials used in the temporary and final restorations, and allergic reactions to anesthetics, medications, and materials used in diagnosis or treatment. Furthermore, I consent to the disposal of any teeth, tissues or restorations, which may be removed.

I agree to provide complete and current medical history information. This includes any and all drugs, medications, hospitalizations, past and presents medical disorders and any conditions for which a physician or health care practitioner has been consulted. I understand the need for these questions to be answered truthfully. All questions have been answered truthfully and in my own hand.

I accept financial responsibility for all returned checks and insufficient funds, stop payment and returned check charges to Regency Dental

I have read the above and accept responsibility for these or any other complications, which may arise or result during or following the procedures, which are to be performed at my request. I have not been given or received any guarantees as to results to be obtained from treatment. I am now giving my free and voluntary informed consent for the treatment to be rendered. I agree that if I fail to cooperate fully with the doctor and her team, my treatment can and will be discontinued at any time. I accept financial responsibility for all returned checks and insufficient funds, stop payment and returned check charges to Regency Dental. **I also understand that I am financially responsible for dental treatment rendered to me by Regency Dental, regardless of what my dental insurance may or may not cover.**

_____ _____

Signature (Patient/Parent or Guardian) Date

_____

Patient Name (Please Print)