GEORGE A. EZZI, D.M.D.
Pleasant Dental Center
126A Pleasant Valley Street Suite 4 Methuen, MA 01844
P: 978-688-9200 F: 978-688-4949
Email: pleasantdentalcenter@comcast.net

Informed Consent For General Dental Procedures

You the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments, if you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be provided

I understand that during my course of treatment that the following care may be provided:

Examinations	Preventative Services	Periodontal Treatment
Restorations	Root Canal	Local Anesthesia
Removable Appliances	Crowns	Bridges

Patient Initials___________

2. Drugs and Medications

I understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Patient Initials__________

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 that were not discovered during examination, the most common being root canal therapy following routine restoratives procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Patient Initials_________

____
Patient name (please print)

___________________________ ______________
Signature (patient, parent or guardian) Date

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Cell Phone and Email Use Policy

I provide the consent to Pleasant Dental Center to use my cell phone number to

- **Call**
- **Text regarding appointments**
- **Leave a message**
- **Email**

I consent to Pleasant Dental Center to call using my cell phone regarding dental treatment, insurance, and my account. I understand that I can withdraw this consent at any time.

My phone number is: ______________________________

Email: ____________________________

Patient Signature: ________________________

Date: _____________________

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Pre-Med Questionnaire

Has anyone (doctor, dentist) told you that you need to pre-medicate before dental treatment due to heart murmur, hip or joint replacement?

YES NO

If YES- reason for pre-med: ______________________________

Are you taking a daily dosage of Aspirin? ______ Dosage: _____

Dr.'s Name: ______________________________

Dr.'s Address: ______________________________

Dr.'s Tel.#: ______________________________

______________________ ______________________________
Print name of Patient Signature (patient, parent or guardian)

____
Date

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Written Financial Policy

Thank you for choosing Pleasant Dental Center. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

You can choose from:

- Cash, Check, Visa, MasterCard, American Express, Discover or Care Credit

For our patients without dental insurance we offer a 10% discount if services are paid in full prior to treatment with cash or check.

We offer a senior citizens (65+) discount of 10%.

Please note:

Pleasant Dental Center requires payment prior to the beginning of your treatment.

For treatment plans larger than $500 or more a 20% deposit is required to schedule your initial treatment appointment.

Patients with a dental insurance, as a courtesy to you, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $50 is charged for patients who miss or cancel an appointment without 24 hour notice. Our office reserves the right to discharge a patient who accrues two or more missed appointments.

Pleasant Dental Center charges $25 for returned checks and a finance charge on any outstanding balance.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

____________________ ____________________ __________

Signature (patient, parent or guardian) Print name of Patient Date

RECORDS RELEASE FORM

Date ____________

To ____
(Previous Office/Doctor name)

Address ____

City ____________ State ____________ Zip____________

Phone # ________________ Fax# ________________

I authorize the release of my dental records and medical records relevant to dental treatment, or copies of such, and request that they are transferred to:

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Please list any other family members:

Name	Relationship
1. ________________________	________________________
2. ________________________	________________________
3. ________________________	________________________
4. ________________________	________________________

______________________________ ______________________________

Print name of Patient and SS# Signature (patient, parent or guardian)