Hingham Dentistry
169 Lincoln Street, Suite 101
Hingham, MA 02043
781-740-0100

Informed Consent for Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by the doctors of Hingham Dentistry. 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 the doctors of Hingham Dentistry and all of your questions are answered. By consenting to the treatment, you are acknowledging that your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide the doctors of Hingham Dentistry with accurate information before, during, and after treatment. It is equally important that you follow the doctors' of Hingham Dentistry 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 the doctors of Hingham Dentistry, 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, Restorations, Crowns, Bridges, Dentures, Partial Dentures, Implant Restorations, Other.
Patient Initials_____

2. Drugs and Medications
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 (severe allergic reaction). I also understand that partial or full numbing is possible with local anesthetic.
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 restorative procedures. I give my permission to the doctors of Hingham Dentistry to make any/all changes and additions as necessary.
Patients Initials_____

4. I give permission to Hingham Dentistry to bill my dental insurance provider for the treatment provided, if applicable.
Patient Initials_____

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Patient Name (Please Print)

_____ _____
Patient Signature Date