Dr. Michael P Costabile, DMD PA
Dental Associates of Boca Raton

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INFORMED CONSENT

PLEASE READ CAREFULLY:

"The mission of Dental Associates of Boca Raton is to help improve the oral health and dental education of the community. To create a practice dedicated to quality patient care. We are committed to the utmost in care and compassion. We strive to provide access to oral care in a comforting and comprehensive atmosphere; including being at the forefront of technology and having a skillful staff in a synergistic atmosphere that encourages both, patients and staff, to be excited about dentistry."

-Dr. Costabile

Patient's Name _____ *Date* _____

PLEASE INITIAL EACH SECTION AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE SIGNING.

___1. YOUR HEALTH:
I agree to disclose all previous illnesses and medical history. Undisclosed medical information and current medications, allergies or illnesses may compromise my dental treatment.

I understand that latex gloves, antibiotics, local anesthetics and other medications can cause allergic reactions. I have informed Dental Associates of Boca Raton of any known allergies.

I am aware that certain heart conditions and having artificial joints may require pre-medication before starting any dental procedure. I have informed Dental Associates of Boca Raton if I need to be pre-medicated before dental procedures.

I understand that some antibiotics may interfere with birth control pills.

I am aware that Epinephrine in local anesthetic may cause a temporary increase in heart rate. Oral anesthesia may cause bruising and temporary numbness of the lips, cheeks, tongue or other facial tissues. In rare cases, this condition may be permanent.

___ 2. YOUR VISIT:
Florida State Dental Board's regulations require that all new patients undergo a complete dental examination along with a full series of x-rays and periodontal (gum) evaluation.

I understand that if I would like to address a specific concern, a limited problem focused examination will be performed and a complete oral examination will be done at the doctor's discretion.

I understand that gum disease may prevent me from having "just a cleaning." I understand that routine cleanings are not the appropriate treatment for gum disease and other procedures may be necessary.

I agree to have Dr. Costabile and licensed/registered staff to examine and evaluate my dental and oral condition.

___3. YOUR TREATMENT:
I understand that I may have to undergo treatment deemed necessary for dental conditions as diagnosed by Dr. Costabile.

I understand that dental treatment may include, but is not limited to: fillings, crowns, bridges, dentures, extractions, impacted tooth removal, root canals, bone grafts, implants, treatment of periodontal disease or "deep cleanings", orthodontic treatment, cosmetic veneers, teeth whitening, etc.

I am aware that some teeth that require fillings or crowns may require unanticipated root canals at the time of treatment or, in some cases, after treatment is done.

I understand there may be changes to my treatment plan as seen necessary by Dr. Costabile. I am aware that certain conditions may not have been evident at the time of examination and may be discovered during treatment. Additional services may need to be added to my treatment plan.

I understand that, in dentistry, no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment.

___4. YOUR OFFICE:
I understand that Dental Associates of Boca Raton will file insurance claims on my behalf as a courtesy to me. I am aware that not all procedures recommended are covered by dental insurance.

I understand that insurance coverage and co-payment quoted is only an estimate and not a guarantee of payment on their behalf. I agree to be financially responsible for all charges incurred.

I agree to pay for services at the time services are rendered. I understand this includes insurance co-payments and private payments; unless previous financial arrangements have been made.

I am aware Dental Associates of Boca Raton may require a pre-payment towards treatment if appointment is 2 hours or more in length.

I agree to arrive on time for my scheduled dental appointments to allow adequate time for treatment. I understand that arriving more than 15 minutes may result in losing the appointment and a broken appointment fee may apply.

I understand that in order to cancel an appointment I must give at least 48 hours notice. If I fail to give proper cancellation notice, a broken appointment fee may apply.

I am aware that Dental Associates of Boca Raton will forgive the first occurrence of this policy as a courtesy to me. I understand that if I continue to fail and break appointments, I will have to pre-pay for treatment in full in order to schedule future appointments or I may forfeit the privilege to schedule future appointments.

CONSENT: I have been given the opportunity to have all my questions answered. My signature below signifies that I understand this informed consent put forth by Dental Associates of Boca Raton.

Patient or Guardian's Signature _____ Date _____