DENTAL TREATMENT CONSENT FORM

I hereby authorize Dr. George Lundstrom, and his assistants to perform the following dental treatment plan. If any unforeseen condition arises in the course of treatment calling for procedures in addition to, or different from those now contemplated, I wish to be informed and involved in the decision for alternative treatment.

I am informed and fully understand that inherent in any type of dentistry includes the possibility of unavoidable complications. I am aware that the practice of dentistry is not an exact science. I do not hold Dr. George Lundstrom responsible for any common complications of dentistry. This may include teeth sensitivities, the need for endodontic treatment, TMJ problems, and gingival or mouth tissue sensitivities. I further realize that in spite of the possible complications, my contemplated dental work is desired by me.

I realize that it is mandatory that I give an accurate and complete medical history, and follow all instructions as directed by Dr. Lundstrom to ensure optimum results from my dental treatment.

I give you my permission to call my cell phone.
I agree to pay what Insurance does not pay.

The following dental procedures may be included in my treatment plan:

- dental examination
- dental X-rays
- diagnostic photographs
- prophylaxis
- fluoride treatment
- sealants
- restorative treatment
- cosmetic treatment
- periodontal treatment
- endodontic treatment
- oral surgery
- orthodontic
- photos

Any questions about my proposed dental treatment have been fully answered. I have read this statement and understand it completely.

Patient: _____ Signature:_____ Date:_____

Doctor: George Lundstrom D.D.S. Signature:_____ Date:_____

Witness: _____ Signature:_____ Date:_____