GENERAL CONSENT FORM

Please read this form carefully. Should you have any questions, our office manager will be delighted to help you.

1. I hereby authorize and direct Dr. Angelina Anisimova and dental auxiliaries/dental hygienist to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
2. I understand that certain parts of the treatment may be performed by certified paraprofessionals (Dental assistants) other than the dentist.
3. I also authorize Dr Anisimova and dental auxiliaries to take and to use photographs, radiographs, other diagnostic materials and treatment records of my face, jaws and teeth, before, during and after treatment for the purposes of teaching, research, and scientific publication. The photographs shall be used for dental records, marketing materials (including website and printed materials) and if in the judgment of Dr. Anisimova, dental research, education, or science will be benefited by their use. Such photographs, diagnostic and treatment information may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which s/he may deem proper in the interest of medical education, knowledge, or research. It is specifically understood that in any such publication or use no patient will be identified by name and full face will not be used (Identifying information will be kept confidential). The aforementioned photographs may be modified or retouched in any way that my dentist, in her discretion, may consider desirable.
4. I understand x-rays, photographs, models of the mouth, and/or any other diagnostic aid used for an accurate diagnosis and treatment planning are the property of Dr. Anisimova but copies are available upon request. I also understand I do not expect compensation, financial or otherwise, for the use of photographs.
5. In general terms, the dental procedure(s) can include but not be limited to:
   a. Comprehensive oral examination radiographs, cleaning of the teeth, and the application of topical fluoride.
   b. Application of plastic "sealants" to the grooves of teeth.
   c. Treatment of disease, or injured teeth with dental restorations (fillings), crowns, or root canal treatments.
   d. Oral Surgery: Extraction of one or more teeth.
   e. Placement of space maintainers and/or replacement of missing teeth with dental prosthesis.
   f. Treatment of Disease or injured oral tissues secondary to traumatic injuries and/or accidents and/or infection.
6. I understand the Dr. Anisimova is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement.
7. I realize the guarantees of results or absolute satisfaction is not always possible in dental health service.
8. I have answered all the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told Dr. Anisimova or other staff member about all medical conditions, including allergies, I also understand if I or my dependent ever had any changes in health status or any change in medications(s), I will inform Dr. Anisimova at the next appointment
9. I authorize Dr. Anisimova' s office to forward a review of findings and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care giver for his/her records, as well as any third parties such as insurance companies who may request information.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

Patient name _____

Signature _____ **Date** _____