Tri-Cities Center for
Cosmetic Dentistry

KATHY S. SANDERS, DMD, AAACD

Informed Consent for Treatment

This section describes the agreement between Dr. Kathy Sanders and you, the patient, regarding dental treatment to be provided. The following provisions apply:

1) Dr. Sanders will provide dental services according to accepted general and/or cosmetic dental procedures. However, patient satisfaction with the outcome cannot be guaranteed. While every reasonable attempt will be made to achieve the result desired by the patient, Dr. Sanders will ultimately have final discretion regarding the acceptability of treatment provided. Dr. Sanders will not be responsible for the fees associated with further treatment and/or re-treatment the patient may elect to receive.

_____ **(Please initial)**

2) The patient understands that attempted restoration of some teeth may require further treatment and/or extraction by a specialist, such as an endodontist, periodontist and/or oral surgeon. Fees for such services, should they be required, are not in the estimate provided by Dr. Sanders. The patient assumes full responsibility for fees arising from services provided by any provider to which the patient is referred.

_____ **(Please initial)**

3) The patient understands that restoration of teeth can never be viewed as permanent. Most restorations must be replaced at some time. Fees for restoration replacement and future dental treatment will be the responsibility of the patient.

_____ **(Please initial)**

4) The patient understands that the effect of dental treatment upon pain and sensation in joints, teeth and other areas of the body cannot be fully predicted. While every reasonable attempt will be made to alleviate dental and/or joint pain, it is possible that some discomfort may persist indefinitely. The patient agrees to hold Dr. Sanders harmless for any claims arising from ongoing discomfort, sensation, etc., arising from dental treatment provided.

_____ **(Please initial)**

I understand …
Please print your name and sign below to signify that you have read, understand and initialed the four sections of this document regarding your dental care within our office. Your signature signifies that you are aware of our procedures and that you are in agreement regarding the informed consent. A copy will be provided for your records.

_____Patient Name (Please print)

_____ _____ _____

Patient Signature Date New Patient Coordinator/Front Office Coordinator