Dr. Steven M. Goldy

Welcome, and thank you for selecting our office to provide your dental services. The following is a ***Statement of Informed Consent***, and an explanation of our general office policies. Please read it carefully and initial/sign where indicated.

This initial visit is either for an emergency or for a complete dental examination and evaluation. For an ***Emergency*** visit, the doctor will evaluate only the specific area of concern and treat the signs and/or symptoms accordingly. We may need to refer you to an appropriate dental specialist.

For an initial complete dental examination and evaluation, I authorize the doctor and his/her auxiliaries to take any dental X-rays they feel necessary. I understand that the doctor may not be able to perform any treatment without these X-rays. After the initial examination and diagnosis, the doctor will inform me of his/her recommendation for treatment, as well as any options for such treatment. I understand that this initial visit ***does not include a prophylaxis (cleaning).*** However, the doctor or hygienist may provide this service, if time permits.

INITIAL _____

This is a general dentistry office and we provide a multitude of a general dentistry services including but not limited to: simple fillings (restorations), crowns, bridges, dentures, root canal therapy, oral surgery, simple periodontics, implant, prosthodontics, and aesthetic dentistry. I understand that each of these contains inherent risks and ramifications; some of which will be explained to me at the time such services are rendered. I understand that dentistry is not an exact science and therefore, reputable practitioners cannot guarantee treatment and results. I acknowledge that no guarantee has been made by anyone regarding dental treatment ***I acknowledge these facts and give my consent for general dentistry.***

INITIAL _____

I understand that during treatment; it may be necessary to change or add procedures because of conditions found that were not apparent during the initial examination; the most common being the need for root canal therapy following routine restorative treatment. I give my permission for the doctor to make changes as necessary and I understand that such changes will be explained to me at the time of their discovery.

I understand that any dental insurance that I have, may have co-payments (patient share) for many dental procedures. I understand that I will be informed of such co-payments and that ***I am fully responsible for all fees, due and payable in full at the time services are rendered.***

INITIAL _____

I understand that a cancellation of any dental appointments requires a minimum of 24 hours notice. There is a charge for failing to keep an appointment with less than 24 hours notice. (With the exception of a Monday appointment, notification is required prior to Friday afternoon at 5:00 P.M.) The fee for a missed or cancelled appointment is $50.00 for each 30 minutes of reserved appointment time, which is due and payable ***before*** any future appointments can be scheduled. This agreement is irrespective of any dental insurance plan.

INITIAL _____

I have read and agree to the aforementioned policies.

Patient Signature _____ ***Date*** _____

Dr.signature _____