

YOUR FAMILY DENTIST, PC

DR. YATI YADAV, DDS, FAGD & ASSOCIATES

8390 West Cactus Road #110 ♦ Peoria, AZ 85381 ♦ 623.878.3300 ♦ Fax 623.878.3302

CONDITIONS OF TREATMENT

Patient's Name _____
Last First MI

CONSENT TO DENTAL PROCEDURES

Before receiving treatment, you should ask your doctor about the procedure(s) recommended, and ask any questions you may have before you decide whether or not to give your verbal consent for the procedure(s) that are going to be done. All dental procedures involve some risk of unsuccessful results and complications, and no guarantee is made as to the result of treatment. You have the right to be informed of any such risks as well as the nature of the procedure, the expected benefit, and the availability of alternative methods of treatment, including not having the treatment at all. You have the right to consent to or refuse any proposed procedures at any time prior to its performance.

To keep you more comfortable during treatment you may receive a local anesthetic or possibly a sedative. In rare instances patients have an allergic reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing foreign objects during treatment. There is also a small risk of nerve damage as a result of a local anesthetic injection. Sedatives may temporarily make you drowsy or reduce your coordination. If you do take a sedative during the dental procedure, you will need assistance getting home.

X-RAYS

Dental x-rays will be taken as necessary and appropriate for examination, diagnosis, consultation, and treatment procedures.

DENTAL RECORDS

The records, x-rays, photographs, models, and other materials relating to your treatment in the office of Your Family Dentist, PC are the property of the dentist. You have the right to inspect such materials and to request copies. You may request to have copies of your dental x-rays sent to another health care provider by signing a "Release of Records" form.

CANCELLATION POLICY

If you are unable to keep an appointment, you must notify the office at least 48 hours in advance. An appointment that is missed or cancelled with less than 48 hours notice may result in a missed appointment fee. Two cancellations or missed appointments without 48 hours notice may be cause to discontinue further treatment in our office.

Your signature on this form certifies that you have read and understand the information provided, that you have received a copy, and that you accept the terms and conditions described above.

LIMITATION OF LIABILITY

In the case of any liability that arises from any of the services provided here at Your Family Dentist PC, our office will only be liable up to the amount collected from patient for the services rendered.

Patient/Parent/Guardian Signature: _____ Date: ____/____/____