

HAPPY ROCK DENTAL  
5601 N ANTIOCH RD STE. 5  
GLADSTONE MO 64119

I, \_\_\_\_\_, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following as needed:**

1. During the course of treatment at this office, I **may** undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, pediatric dentistry, and radiography. **I will approve and authorize prior to treatment.**
2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
3. While it is anticipated that the planned treatment will be successful, no guarantees can be made about treatment outcomes, restoration longevity, or prognoses. Patients respond differently to different treatments. I understand that any branch of medicine, including dentistry, can involve unanticipated results. ANY and ALL guarantees on dental work performed here are subject to routine checkup recommendations and patient compliance on home care.
4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for *any* costs that my insurance does not cover. **I will provide a credit card number to keep on file. This number will not be run without prior approval. Signing below is my signature to be kept on file for these transactions.**

**A minimum 20% deposit is required at time of scheduling for any patient portion amounts over \$50. All deep cleaning appointments require a 20% scheduling deposit to reserve the time also.**

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff. **The doctor and/or his team and I will discuss any necessary changes before proceeding with treatment. The course of treatment and procedures needed is subject to change from the original proposal to achieve the agreed upon desired result. The dentist's discretion will determine this based on best treatment required for the individual patient.**
6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. It is my responsibility to ask questions if I am uncertain about the dental treatment being suggested.
7. I hereby consent and authorize an employee or agent of Happy Rock Dental to take photographs or videos of me; or to produce video or photographic content that capture my name, voice, and/or image. I authorize Happy Rock Dental to copyright such Materials and use for any educational or promotional purposes, which may include, but are not limited to, professional articles, magazines, brochures, websites, or publications; electronic or otherwise; without notifying me.

\_\_\_\_\_  
Patient or Guardian Name/Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date