MONA GOODARZI, DDS, DENTAL CORPORATION
16300 SAND CANYON AVE, 506
IRVINE, CA 92618
949-201-4444

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:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including, but not limited to, periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

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. I understand no guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

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 insurance pre-estimates are given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

5. I authorize the dentist and/or staff to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third party insurance carriers, payors, and /or healthcare practitioners. I authorize the payment from my insurance carrier to be submitted directly to the dentist/dental practice to be applied directly to any outstanding balance on my account.

6. I understand 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.

7. 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. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____
Patient or Guardian Name Date

_____ _____
Witness Date