RILEY & HAN DENTAL ASSOCIATES, LLC
10 Hawthorne Place, Suite 102
Boston, Massachusetts 02114
Tel: (617) 723-4032 *Fax: (617)723-4059

CONSENT FOR TREATMENT

I, _____, consent to be a patient at the above named office and agree to radiographic and clinical examinations, prophylaxis (cleaning) appointments, restorative and surgical procedures, as needed. I also understand and consent to the following:

1. 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.

2. 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.

3. The treatment plan developed for me may need to be altered as the condition of my mouth changes and I may be referred to dental specialists outside of this office to help address my treatment needs. I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist and dental staff.

4. I will pay in full any costs of treatment or insurance co-payments 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.

5. 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.

_____ _____
Patient or Guardian Name Date

_____ _____
Witness Date

Electronic Communication Consent:

1. ☐ I provide consent to Riley Dental Associates, LLC to use my cell phone number or email address to ☐ call ☐ text ☐ email me regarding appointments, treatment, insurance and my account. I understand that I can withdraw my consent at any time.

   Cell Phone Number: (include area code) _____ _____ (initial)

   Email Address: _____ _____ (initial)