



Patient Consent

- I authorize and give consent to NOVA Family Dental, the Dentist and his/her staff to administer treatment, including but not limited to local anesthesia and other such treatments, which; in their judgment, may be necessary for the prudent exercise of medical or dental care. I understand that the use of medications, anesthetics and some procedures embody a certain risk.
- I acknowledge that no guarantee or assurance has been given by anyone as the results that may be obtained.
- I understand that during the procedure(s) unforeseen conditions may arise that necessitate different procedures from those that were planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment of the dentist.
- I consent to the disposal of any dental tissues or bio-hazard that may be removed.
- The attached medical and dental history was completed fully and accurately to the best of my knowledge.
- I hereby authorize payment of my insurance benefits, otherwise payable to me , to NOVA Family Dental. In the event of legal action of this account, I agree to pay any and all costs of such suit, collection and attorney fees. I have reviewed the treatment plan and authorize the release of any information relative to this claim.
- I have had the opportunity to review the NOVA Family Dental Notice of Privacy Practices.

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