Informed Consent

I (patient's full name) _____ authorize _____ and their staff to perform all necessary dental procedures as explained to me prior to treatment and any other procedures deemed necessary or advisable to complete the planned treatment. I also understand that I may only receive emergency care or limited dental care during today's appointment.

I have had an opportunity to discuss my health history, including any serious dental problems and/or injuries. I furthermore certify that the medical and health history provided to the treating dentist(s) is complete and accurate to the best of my knowledge.

I (patient's full name) _____understand that the dental care I receive today will be provided at no cost. I fully understand that by giving my consent to the provision of dental diagnosis, care and treatment at no cost, I have relinquished my right to legal action against the providing dentist(s) and his/her/their practice for any problem related to that treatment pursuant to the provisions contained in §2305.234 of the Ohio Revised Code, unless the problem is a result of willful or wanton misconduct on the part of the treating dentist(s).

I acknowledge that I have been informed of and understand the provisions of Ohio Revised Code §2305.234 prior to receiving treatment.

I acknowledge that I am of sound mind and free from duress and any undue influence. I have had the opportunity to read and I fully understand the terms and conditions contained in this consent and by signing below I agree to said terms and conditions.

_____
PRINTED NAME OF PATIENT

_____ _____
Signature Date

_____
Patient or Authorized Patient Representative