# WEST HARTFORD FAMILY DENTISTRY, P.C.

Roy Shakun, D.M.D.
Nicholas B. Calcaterra, D.D.S.
Jason Leung, D.M.D.

## General Consent and Statement of Responsibility

I, (print name) _____ have been informed by Dr. Roy Shakun, Dr. Nicholas Calcaterra, or Dr. Jason Leung, of the need to undergo dental treatment as presented to me.

I have been fully informed about the details of the recommended treatment and alternatives, and accept the treatment as recommended by the doctor. I understand that as the treatment proceeds there may be need to change the treatment plan. If this occurs I expect to be informed before any change is instituted. I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following any treatment, I agree to report them to the office as soon as possible.

I have been told that the success of the recommended treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, and reporting to the office any changes in my health status such as taking any prescribed medications as soon as possible.

I have discussed all the above with the Doctor / Hygienist, and all my questions have been answered. I acknowledge that no guarantees or assurances have been given by anyone as to the result that may be obtained.

I am aware that West Hartford Family Dentistry, P.C. cannot guarantee my receipt of benefits from the insurance company for treatment. I understand that any portion not covered by my insurance is my responsibility and any such balance is due payable upon the date services are rendered, unless written financial arrangements have been made. My signature confirms that I will assume full responsibility for my dependents' and my balance. I understand and agree that if my account is turned over for collection, I will be responsible for reasonable attorney fees and court costs. I understand that my failure to cancel scheduled appointments without at least 24 hours notice will result in charge as posted in the reception area.

_____ _____

Patient Signature Date If minor, Signature of Parent or Guardian

_____ _____

Witness Signature Doctor / Hygienist Signature

**Annual updates:**

Patient's Signature _____Date_____

Patient's Signature _____Date_____

Patient's Signature _____Date_____

Patient's Signature _____Date_____