GEORGE W. BUTZ III, DDS, PA

1517 THIRD STREET SE, WINTER HAVEN, FL 33880

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 routine maintenance, periodontics (gum treatment and surgery), oral surgery, fixed and removable prosthodontics (crowns, bridges, and partials), implant dentistry, restorative dentistry, and radiography. I may be referred to specialists for some treatment.
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 relevant to my dental treatment. I will inform the dentist or his staff when changes in my medical history/medications occur.
3. No guarantees, warranties, or assurances have been made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results. Post-operative risks of any proposed treatment may include, but may not be limited to: pain, restricted mouth opening for a time, numbness of the jaw or gum nerves which could persist for some time, gum recession, clicking or pain of the temporomandibular joints, tooth sensitivity to hot or cold which could persist for some time, tooth mobility in selected areas, food lodging between the teeth after meals, requiring cleaning devices such as floss for removal, unaesthetic exposure of crown margins/roots/abutments/implants on teeth or implants immediately or over time. I further understand that, in most instances, if no treatment is rendered my present condition will probably worsen in time.
4. I understand that long-term success requires my long-term continued performance of mechanical plaque removal and my availability for periodic periodontal maintenance visits. I understand that excessive smoking, alcohol, or blood sugar may affect gum healing and health. I agree to follow my doctor and hygienist's home care instructions to improve treatment outcome. I agree to report to my doctor for regular examinations and cleanings as instructed.
5. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance estimate is given or a procedure has been pre-approved or pre-estimated, I am responsible for *any* costs that my insurance does not cover . I understand that Dr. Butz is an out of network provider for all insurances.
6. My treatment plan may change at any time due to various circumstances. 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.
8. I certify that I have had an opportunity to read and fully understand the terms and words within the above consent, and that I have had any questions answered sufficiently, and that the entire form was read before I signed.

_____ _____

Patient or Guardian Signature Date

_____ _____

Witness Signature Date