SAUTTER
FAMILY DENTISTRY

GENERAL CONSENT FORM

SECTION A: PATIENT INFORMATION

Patient Name: _____Date of Birth: _____SSN: _____

IN CASE OF EMERGENCY CALL:

(name) _____ (phone) _____ (relationship) _____

SECTION B: CONSENT TO TREATMENT

I do hereby authorize and request the performance of dental services and the use of whatever procedures Dr. Sautter may deem necessary for my treatment. I understand that Dr. Sautter and their staff will use clinical and patient management techniques that are reasonable, necessary and advisable. I also authorize the administration of anesthetics or analgesics that may be deemed appropriate by Dr. Sautter. I understand that the purpose for using local anesthetics may be therapeutic, diagnostic, or for the treatment of facial pain. I understand that potential complications include but are not limited to pain, swelling, bruising, temporary limited opening, and local infection. I understand that in occasional cases the anesthesia may be prolonged and in very rare cases permanent.

I understand that I am responsible for obtaining any current x-rays that may have been taken at a previous office.

I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since the initial examination and extent of dental pathology. Occasionally, once the treatment plan has been started, complications may arise that dictate additional procedures or treatment. Dr. Sautter, or their staff will always advise me of any changes. I understand that my relevant personal health information may be released to my insurance company in order to get reimbursement.

In the event that Dr. Sautter, or a staff member is exposed to my blood or other bodily fluids, I agree to have my blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C virus (HCV), and the human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and that person would be advised of my rights regarding protected health information.

SECTION D: SIGNATURE

→Patient Signature: _____ Date: _____

If the patient is a minor, or if this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Signature of Parent, Guardian or Personal Representative: _____

Printed name: _____ Relationship to patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

7725 Ballantyne Commons Pkwy – Suite 201 – Charlotte, NC 28277