Dental Associate Group, LLC
4154 Madison Avenue, 2nd Floor, Trumbull, CT 06611
Phone # 203-374-0000 Fax # 203-374-0002
Email: info@dentalassociategroup.com
www.dentalassociategroup.com

CONSENT FOR TREATMENT

I authorize examination and treatment as necessary by or under the supervision of Dental Associate Group Provider. This includes exposure of Radiographs as necessary, use of local anesthetic, reasonable restraint as needed, and use of appropriate medicaments and material for such treatment.

I understand that caries removal, crown preparations, and other restorative procedures can result in a pulp exposure. I also understand that when the pulp exposure does not occur, the pulp may still be damaged due to exposure to heat and other factors during performance of the above mentioned procedures. Whenever the pulp exposure does occur or/and the pulp does get damaged, the appropriate treatments may be required, such as vital pulp therapy, root canal treatments, apexogenesis, apexification, and other. These treatments are in addition to the restorative procedure and may/may not be covered in full or at all by insurances. The alternatives to these treatments are doing nothing or extraction. Understanding the above risks and consequences, I agree to have the caries removal and/or restorative treatments including and not limited to fillings and crown preparations performed.

I READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN ME VERBALLY. BY MY SIGNATURE BELOW I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.

Patient Name (Print the Name):_____

Patient/Parent (Guardian)
Signature:_____**Date:**_____