NEW PATIENT
INFORMED CONSENT

TARA KAUR DDS
& ASSOCIATES

I, _____ , consent to being a patient of Tara Kaur, DDS, PLLC and agree to a clinical and radiographic examination. By becoming a patient of Tara Kaur, DDS, PLLC, I understand, agree and consent to the following:

— I will provide a thorough and complete medical and dental history. I will supply a full list of my prescription medications, over the counter medications, vitamins, supplements, homeopathic remedies, herbs and/or any other medicament I am currently taking. I will include dosages and reason(s) for taking each of the above mentioned.

— I consent to Tara Kaur, DDS, her associates and employees to communicate with my other medical and healthcare practitioners, if necessary, to inquire about any aspect of my medical or dental history.

— I understand due to the nature of dentistry, unexpected situations arise. Therefore, Dr. Tara Kaur, her associates and employees will attempt to be as punctual as possible. However, if delays occur, I will be informed promptly and be able to choose whether I wait or reschedule my appointment as needed.

— I understand dental radiographs (xrays) are essential tools for the holistic assessment of my oral health as well as various oral diseases. I authorize Dr. Tara Kaur and / or her associates to use her professional judgement in ordering dental radiographs to provide appropriate care.

— I understand that during dental treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. If any deviation occurs from the original agreed upon treatment plan, a new treatment plan will be established and reviewed with me. I will do my best under stressful conditions to approach my dental care with optimism and open communication with my dental care team.

— No guarantees can be made about dental treatment outcomes, restoration longevity or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results. It is my responsibility to assess the risks inherent in the dental procedures I consent to and to accept responsibility for the outcome(s) of my decision(s).

— I will pay in full all fees for services rendered the day the service is provided.

— I understand a 48 hour notice is required for canceling or rescheduling dental appointments. Improper notice may result in a $125 missed appointment fee.

— I am welcomed to ask questions about any aspect of my dental care. I will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment I am unsure about.

Patient Name: _____

Patient Signature: _____

Date: _____