Office Policy

The staff here at Creating Smiles Dentistry is committed to providing outstanding dentistry. By consenting to the treatment recommended by the dentist you are helping us to maintain the extraordinary level of care.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that anesthetic agents embody certain risks. I understand that I can ask for a complete recital on any possible complications.

I understand a treatment option is to receive no treatment. I also understand that I have a right to refuse any treatment Dr. Nguyen recommends by signing a separate refusal of treatment consent form consisting of risks of no treatment. I further understand that unwillingness to sign a refusal of treatment form or refusal of multiple recommended treatments could lead to dismissal from Dr. Nguyen's care.

I understand that during the course of treatment, conditions not evident during examination may necessitate procedures different from those planned and may need a specialist for necessary treatment. I understand that I will be notified of any necessary treatment changes as well as cost differences. I understand any costs incurred from a specialist are my responsibility.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that waiting on treatment needed may compromise the treatment initially proposed, which may necessitate more extensive treatment/procedures.

I hereby give Dr. Nguyen the absolute right and permission to use my photographs/slides for education or promotional purposes. The undersigned completely and forever releases any right to present of future compensation in connection with the use of the said photographs/slides.

I understand that my treatment can not be discussed outside of my presence to anyone, unless written notification is given to the Office Manager. This is to ensure privacy and that dignity of all involved, as well as obeying HIPPA regulations. If at any time I use profanity or threatening language towards the office staff in an offending manner, I understand I can be dismissed from care. The office phone number is for true dental emergencies and my call will be returned within reasonable timeframes.

CONSENT: I have had the opportunity to have all my questions answered by my doctor, and I certify that I understand. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

________________________________ ________________________

Signature of Patient Date