

Wooster Dental - General Consent Form

Welcome to Wooster Dental! We are committed to providing you with the best possible dental care. Please read the following information carefully. Your signature confirms that you understand and agree to the terms outlined below.

1. Consent for Dental Treatment

I, the undersigned, consent to dental procedures deemed necessary or advisable by the dental professionals at Wooster Dental. This includes but is not limited to examinations, x-rays, preventive services, fillings, crowns, root canals, extractions, and other procedures recommended by my provider. I understand that, as in all healthcare, results cannot be guaranteed and that there may be risks and possible complications associated with any dental procedure.

2. Financial Responsibility

I understand that I am financially responsible for the costs of the services provided by Wooster Dental. I agree to pay for these services in accordance with the office's payment policies. If applicable, I understand that Wooster Dental will file my insurance claims as a courtesy, but I am responsible for any co-payments, deductibles, or costs not covered by my insurance.

3. Acknowledgment of Privacy Practices

I acknowledge that I have been informed of Wooster Dental's Privacy Practices and that my dental records and health information will be kept confidential in compliance with HIPAA regulations. I authorize Wooster Dental to use my information for treatment, payment, and healthcare operations.

4. Appointment and Cancellation Policy

I understand that appointments are reserved specifically for me. If I am unable to keep an appointment, I will notify Wooster Dental at least 24 hours in advance. I understand that missed appointments take time from other patients who are waiting to be seen and may make it difficult for Wooster Dental to accommodate me in the future.

5. Consent to Communications

I consent to receive communications from Wooster Dental regarding my appointments, treatment, and billing via phone, text, or email. I understand that I may withdraw this consent at any time by notifying the office in writing.



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Patient Acknowledgment and Signature

I have read, understand, and agree to the information provided above. I consent to the dental treatment, policies, and financial responsibility as outlined. I understand that I may ask questions about this consent form at any time.

Patient Signature

Date

WOOSTER DENTAL

