Ghina Morad, DMD
Beautiful Faces, Radiant Smiles

Consent Form

We are complimented that you have selected us to provide dental care for you.

I ,_____, give consent for myself/my child to receive dental treatment deemed necessary by Dr. Ghina Morad and staff. These procedures include, but are not limited to; examinations, x-rays, oral prophylaxes, fluoride treatments, sealants, restorations such as composite fillings and crowns, periodontal treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. This consent shall be considered in effect until rescinded or revoked.

Changes in Treatment Plan: I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give my permission to the dentist to make any/all changes and additions as necessary.

Risk of Dental Procedures: May Include but are not limited to, complications resulting from the use of dental instruments, drugs, medicines, analgesics, anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, Thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular jaw (TMJ) joint difficulty and injury to other tissues, referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

Release of Photos: I understand the use of photos, videos, or other images taken may be used by Ghina Morad D.M.D, using my name or a fictitious name in media form. I release any and all claims whatsoever in connection with the use of my photography, name and reproduction of material.

For children under the age of 18:

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I authorize the release of information of information for my child to these parties:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

By signing this Consent Form, I have read, understand and agree to the terms and conditions.

Signature: _____ Date_____