Foster City Dental Care
675 Mariner's Island Blvd., Suite #110
San Mateo, CA 94404
Phone: (650) 577-1988 FAX (650) 577-0835

CONSENT FOR COMPREHENSIVE EXAMINATION AND/OR X-RAYS

I, _____, hereby authorize Foster City Dental Care to conduct a comprehensive examination of my dental health to thoroughly assess and record existing dental conditions. By evaluating what is seen visually and what is evidenced on x-rays, my dentist can detect advancing tooth decay; the need for root canal therapy; bone loss and other gum conditions (periodontal disease); cysts; abscesses; infections that are developing in the teeth, gums, bone, head and neck regions; evidence of benign & malignant tumors; the progress of un-erupted teeth and the affects of missing teeth. The diagnostic information obtained from a comprehensive examination and x-rays is valuable in analyzing changes that occur over time and to effectively make recommendations that will cause the least possible impact both health-wise and financially.

I understand that dentistry is not an exact science and therefore Foster City Dental Care cannot fully guarantee that all dental conditions will be recognized with this examination. I will always have the opportunity to ask questions and have the right to know the benefits of a recommended treatment along with the associated risks and alternatives before proceeding.

_____ _____
Date Patient/Parent/Guardian Signature

CONSENT FOR LIMITED EXAMINATION AND/OR X-RAYS

I, _____, hereby authorize Foster City Dental Care to conduct a limited examination and/or necessary x-rays. I understand my dentist will only attend to the single issue I am here today for and make the appropriate diagnosis for this issue only. As a result Foster City Dental Care will not be able to make recommendations, explain risks and alternatives or provide appropriate dental treatment for any un-diagnosed condition(s) not focused on today.

I further understand that I must return to Foster City Dental Care for a comprehensive examination and complete diagnostic x-rays so that a more thorough, overall evaluation of my dental health can be conducted including: tooth decay; the need for root canal therapy; bone loss and other gum conditions (periodontal disease); cysts; abscesses; infections that are developing in the teeth, gums, bone, head and neck regions; evidence of benign & malignant tumors; the progress of un-erupted teeth and the affects of missing teeth.

I understand that dentistry is not an exact science and therefore Foster City Dental Care cannot fully guarantee that all dental conditions will be recognized with this examination. I will always have the opportunity to ask questions and have the right to know the benefits of a recommended treatment along with the associated risks and alternatives before proceeding.

_____ _____
Date Patient/Parent/Guardian Signature