Dental Home Services, LLC
The Dentist Who Comes To You!
Dr. Stuart Rubin and Associates
1-800-842-4663
973-763-3319(Fax)

Date: _____

Dental Treatment Consent Form

Patient's name:
Address:
Facility name (if not private residence):
Street:
City: State: Zip Code:

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. I understand that proposed treatment may change based on conditions found during the course of treatment that were not visible during the initial examination. I also understand that the treatment rendered may be different than traditional treatment due to considerations of the patient's age, medical condition, and out of office treatment environment. I understand the risks of not having recommended treatment performed. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist for diagnostic purposes or dental treatment.

I have received information about the proposed treatment, possible complications and risks, and in spite of this, I realize the contemplated treatment is necessary and desired by me. I give my consent and authorization for Dental Home Services LLC, Dr. Stuart Rubin, and his assigned associates to provide dental treatment to the above named patient. I also accept full financial responsibility, regardless of insurance coverage, for the dental treatment rendered on this patient. I understand this treatment is not covered under Medicare. I am the legal guardian or authorized agent of the patient.

Name:
Relation to patient:
Address:

Home phone:
Cell phone:
Work phone:

Signature: _____