OTTAVIANO
DENTAL

CONSENT FOR TREATMENT & COMMUNICATION AUTHORIZATION

CONSENT FOR DENTAL TREATMENT

I, the undersigned patient (or legal guardian), hereby authorize **Ottaviano Dental** and its clinical staff to perform dental examinations, diagnostic procedures, and treatment as deemed necessary for my dental care.

This may include, but is not limited to:

- X-rays and diagnostic imaging
- Preventive care (cleanings, exams)
- Restorative treatment (fillings, crowns, etc.)
- Periodontal therapy
- Oral surgery procedures
- Administration of local anesthetics and medications as needed

I understand that:

- No guarantees have been made regarding treatment outcomes.
- I have the right to ask questions and decline treatment at any time.
- Risks and benefits of treatment will be explained prior to procedures.

OTTAVIANO
DENTAL

COMMUNICATION CONSENT

I authorize **Ottaviano Dental** to contact me regarding my dental care, including appointment reminders and scheduling, treatment information and follow-ups, insurance and billing matters, and office updates and notifications

I consent to being contacted via:

☐ Phone call
☐ Voicemail messages
☐ Text messages
☐ Email

I understand that standard message/data rates may apply for text/email communication.

ACKNOWLEDGMENT & SIGNATURE

I have read and understand this Consent for Treatment and Communication Authorization and voluntarily agree to its terms.

Patient Name: ___________________________________

Signature: ______________________________________

Date: ____

If signed by representative:

Representative Name: ____________________________

Relationship: ___________________________________

Ottaviano Dental

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