Shelley Kaur, DDS
3905 Park Drive, Suite 205
El Dorado Hills, CA 95762
916-939-6900

CONSENT FOR TREATMENT

1. I understand that the information that I have provided is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the dentist in any changes in my health or medication.
2. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
3. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
4. I agree to the use of anesthetics and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
5. **Filling Materials:** Although the FDA and other public health organizations have investigated the safety of amalgam used in dental fillings and concluded that no valid scientific evidence has shown that amalgams cause harm to patients with dental restorations, except in rare cases of allergy, the dental office of Dr. Angel Sun only uses Composite Resin for dental fillings. I understand that some insurance policies only cover Composite Resin fillings on anterior (front) teeth.
6. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. Our office accepts cash, checks, MasterCard, and Visa. **Dental Health Benefits:**

We accept most dental health benefit plans. However some plans have restrictions on your choice of dentist. Please contact your benefit plan for clarification. As a courtesy, we will gladly bill your insurance, either manually or electronically.

7. **Cancellation Policy:** We require that patients give us 24-hour notice if they are unable to keep an appointment. There will be a $50 charge for missed appointments. Less than a 24-hour cancellation is considered a missed appointment. Patients with more than three missed appointments may be subject to dismissal.

I have read, understand, and accept the above consent for treatment.

Patient's Name:_____ Patient's Date of Birth:_____

Signature of Patient, Parent, or Guardian_____ Date_____

NOTICE OF PRIVACY PRACTICES AND DENTAL MATERIALS FACT SHEET

I acknowledge that I have received a copy of the Notice of Privacy Practices with the effective date of October 31, 2008 and the Dental Materials Fact Sheet.

_____. _____.

Signature of Patient, Parent, or Guardian Date