General Informed Consent for Examination and Treatment

The purpose of this informed consent form is to provide an opportunity for patients (and/or their guardians) to understand and give permission for the performance of general services involved in dental care.

______ 1. I understand and accept that Dr. Anne Barnes, DMD and/or the providers of Berkshire Dental Arts will, in the course of their clinical duties, perform:
   a. Examination and diagnosis of oral health
   b. Prophylactic teeth cleaning
   c. Diagnostic X-rays (radiographs)
   d. Intra- and extra-oral photography
   e. Treatment planning
   f. Use of local anesthetics and basic restorative and preventative procedures

______ 2. I understand and accept that in regards to photography (both intra- and extra-oral), I consent to the use of these images for patient identification, documentation of oral conditions and treatment, and/or for communication with dental laboratories or other healthcare providers.

______ 3. I understand that payment is due at time of services rendered and that I am responsible for payment of all dental fees not paid in full by any insurance or other applicable coverage. I hereby allow Berkshire Dental Arts PC to bill my insurance provider, if any.

______ 4. By signing this form, I freely give my consent to authorize the providers at Berkshire Dental Arts to render my treatment as necessary or advisable for my dental conditions, including any and all anesthetics and/or medications. I understand that my informed consent for examination, diagnosis, and treatment shall remain in effect until I am no longer regarded as a patient of record.

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Patient's name (please print)	Signature of patient or legal guardian	Date