Informed Consent

for the office of

K. Ragunanthan, D.D.S., M.S., Inc.
603 13th Street NW, Canton, OH 44703
330-453-8787

The undersigned hereby authorizes K. Ragunanthan, D.D.S., M.S., Inc. and/or any of his staff to perform the following treatment:

_____ General Dentistry to include but not limited to: exams, cleaning, x-rays (or other diagnostic aids deemed necessary by Doctor to make a specific diagnosis of my oral health), fillings, crowns, periodontal therapy, limited orthodontic services, routine oral surgery, fabrication of appliances or other services as explained to me when my treatment plan was presented or any procedure, medication, or therapy deemed necessary for the comprehensive care of my oral health and to complete my treatment in a safe and efficient manner.

_____ I further authorize Doctor to share information regarding my treatment with any referring dental/medical professionals as deemed necessary to provide me with optimal care. In addition, any information regarding my care may be shared with my insurance company for the purpose of obtaining any benefits due me as a result of any claims made.

_____ Doctor and/or his staff has explained to me that there are certain unforeseen and/or potential risks in my treatment/procedure. No guarantee has been given to me that the proposed treatment will be curative and/or as long lasting as I feel is appropriate. The success rate of the various treatments depends on the diligence of each individual patient's oral home care and personal habits.

Date_____ Patient's signature_____

Patient's Name Printed_____

Date_____ Dentist's signature_____

Date_____ Witness' signature_____