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Informed Consent Form for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so s/he can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling, and discomfort after treatment.
2. Infection in need of medication, follow-up procedure or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations or gums.
5. Possible deterioration of your condition which may result in tooth loss.
6. The need for replacement of restorations, implants or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
9. Root tip, bone fragment or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop.
10. Jaw fracture.
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
12. Allergic reaction to anesthetic or medication
13. Need for follow-up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Patient Signature _____ Date _____

Witness _____ Date _____

Print Patient Name _____

Parent/Legal Guardian _____ Date _____

Financial Information Regarding your Dental Insurance

If you do not have Dental Insurance, payment is due on the day of service. We accept all major credit cards, we also accept personal checks and cash.

If you have coverage under your Dental Insurance, we submit a pre-treatment estimate to your insurance company for procedures $300 and above. It may take 4-6 weeks for your insurance company to process the pre-treatment estimate and return to our office. A copy of the estimate will then be mailed to your home addresss with an "estimate" of the out-of-pocket cost that will be due at the time of your appointment. Please keep in mind that a patient can exceed the annual maximum benefits for the year, thus further increasing your out-of-pocket expenses once the claim has been processed and paid by your insurance. Please note that if for any reason your insurance company does not fulfill their obligation, or your treatment is completed before we receive a pre-treatment estimate, you will be responsible for any balance that is incurred.

We also recommend that you become familiar with your insurance company guidelines, which can be obtained by calling the customer service number on the back of your card, or via insurance company website.

I agree to a fee of $50 for any appointment that is broken or not cancelled with a twenty-four (24) hour notice.

Signature: *Date:*

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Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ (Last Name / First Name / Initial) Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Primary Insurance

Person Responsible for Account _____ (Last Name / First Name / Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance

Insured Name _____ (Last Name / First Name / Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Dental History

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

Medical History

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Kidney Disease ☐
- Latex Sensitivity ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____