Absolute Dental

Today's Date_____

PATIENT INFORMATION

Name: Last: _____ First: _____ Middle: _____ DOB: _____

Gender: ☐ Male ☐ Female **SSN**#: ___-___-___ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone # _____ Work # _____ Cell # _____

E-mail Address: _____ Is it ok to Text and/or E-mail you? ☐ Yes ☐ No Initials _____

Address: _____ City: _____ State: _____ ZIP: _____

Employer: _____ Occupation: _____ Work #: _____

Is the patient a student? _____ ☐ Full Time ☐ Part time Emergency Contact Person: _____ Phone #: _____

Spouse or Parent's Name: _____ Employer: _____ Work #: _____

Have you or any member of your family been a patient at this office before? ☐ Yes ☐ No If yes, names: _____

Who may we thank for recommending our office to you? _____

Otherwise, how did you learn about our practice? ☐ Insurance ☐ Internet ☐ Mailer ☐ Yellow Pages ☐ TV-channel ☐ Other _____

ACCOUNT RESPONSIBLE PARTY

Person responsible for Account: _____ Currently a patient in our office(s)? ☐ Yes ☐ No

SSN#: ___-___-___ DOB: _____ Driver's License: _____ State: _____

Home Phone# _____ Cell# _____ Other: _____ Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

PRIMARY DENTAL INSURANCE

Insured's Name: _____ DOB: _____ Relation to Patient: _____

SSN#: ___-___-___ Member ID: _____ Effective Date: _____

Insurance Carrier _____ Phone# _____ Employer: _____

Address: _____ City: _____ State: _____ ZIP: _____

Group or Policy# _____ Union/Group Name: _____ Local#: _____

SECONDARY DENTAL INSURANCE

Insured's Name: _____ DOB: _____ Relation to Patient: _____

SSN#: ___-___-___ Member ID: _____ Effective Date: _____

Insurance Carrier _____ Phone# _____ Employer: _____

Address: _____ City: _____ State: _____ ZIP: _____

Group or Policy# _____ Union/Group Name: _____ Local#: _____

Thank you for choosing Absolute Dental for your dental needs. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.
In order to maintain our records up to date, this form must be completed every 6 months.

DENTAL HISTORY

What is the primary reason for your dental visit today? _____

Are you aware of any dental problems? If so, please explain: _____

Please share the following dates:

Your last complete exam: _____ Your last complete x-rays: _____ Your last dental cleaning: _____

Was there any dental treatment your last dentist recommended for you? If so, please describe: _____

If your dental treatment was not completed, what prevented you from receiving it? ☐Time ☐Cost ☐Fear ☐Other_____

Why did you leave your last dentist? _____

Previous dentist name: _____ City: _____ State: _____ Phone #: _____

Please check any of the following problems that apply to you:

☐Sensitivity (hot, cold, sweets)
☐Loose, tipped or shifting teeth
☐Jaw Joint pain
☐Treatment for TMJ
☐Bleeding, swollen or irritated gums
☐Teeth or fillings breaking
☐Bad breath or bad taste in your mouth
☐Wear a night-guard
☐Tooth pain when chewing
☐Dry mouth
☐Grinding/clenching teeth
☐Braces

Please indicate current/past dental treatments:

☐Dentures/partial dentures, how old _____U/L _____U/L
☐Deep cleanings/periodontal treatment, when _____
☐Dental Implants, when _____
☐Teeth extracted (adult), when _____

If you could whiten your teeth for a cost you could afford, would you do it? ☐YES ☐NO

If you could change anything about your smile it would be:

☐Make teeth brighter
☐Close spaces
☐Repair chipped teeth
☐Alternative to a denture
☐Get a smile makeover
☐Make teeth straighter
☐Replace metal fillings with tooth colored fillings
☐Replace missing teeth
☐Replace old crowns that don't match

On a scale of 1-10, with 10 being the highest

How important is your dental health to you? _____How would you rate your current dental health? _____

MEDICAL HISTORY

Please check any of the following that APPLIES TO THE PATIENT:

☐Aids/HIV
☐Seasonal Allergies
☐Chemotherapy
☐Excessive bleeding
☐Hepatitis A / B / C
☐Mitral valve prolapse
☐Respiratory illness
☐Stroke
☐Allergies to antibiotics
☐Anemia
☐Asthma
☐Diabetes
☐Fainting
☐High blood pressure
☐Anxiety/ Depression
☐Rheumatic fever
☐Thyroid disease
☐Tuberculosis
☐Arthritis
☐Blood disease
☐Dizziness
☐Glaucoma
☐Low blood pressure
☐Pacemaker
☐Rheumatism
☐Currently pregnant
☐Phen-Fen (diet pills)
☐Artificial joints
☐Bruise easily
☐Drug addiction
☐Heart conditions
☐Jaundice
☐Osteoporosis
☐Seizures
☐Liver disease
☐Other medical conditions _____
☐Artificial heart valve
☐Cancer
☐Emphysema
☐Heart Murmur
☐Kidney disease
☐Radiation
☐Stomach Problems
☐Latex allergy

Do you smoke or use chewing tobacco? ☐YES ☐NO How much? _____How long? _____

Do you use any recreational drugs? ☐YES ☐NO Which drugs? _____

What medical conditions are you currently being treated for? _____

Physicians name: _____Phone# _____Fax# _____

Please list any medications you are currently taking: _____

Please list any medications you are allergic to or have bad reactions to: _____

To the best of my knowledge, I have answered every question completely and accurately. It is my responsibility to inform Absolute Dental of any changes in my health and or medications.

Patient/Guardian signature: _____Print name: _____Date: _____

-FOR OFFICE USE ONLY-

Dr. Name: _____Dr. Signature _____Date: _____

Dr. Notes: _____

Vitals BP: _____Pulse: _____

Absolute Dental

Primary Insurance Information

Office: _____

Date: _____

Patient Name: _____ DOB: _____

Name of Insured: _____

Primary Insurance Carrier: _____

Subscriber ID/ SSN#: _____ Subscriber's DOB: _____

Employer: _____

To determine if other insurance coverage is secondary to this plan, please complete the following information, signed and dated.

Are you or any other family members covered by another insurance plan?

Yes _____ No _____ If yes, please complete the following:

Secondary Insurance Carrier: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's ID/SSN#: _____

Group # and Effective Date: _____

Family members covered by plan: _____

_____

Type of coverage (check all that apply):

_____ Medical _____ Dental _____ Vision _____ Prescription

If divorced or legally separated, does the decree specify which parent is responsible for providing health and/or dental coverage for the children: Yes _____ No _____

I certify that the above is true, correct and complete.

Subscriber's Signature: _____ Date: _____

INDIVIDUAL PATIENT'S AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Absolute Dental participates in a network of healthcare providers that accept payment for dental and other healthcare services through CareCredit and other third-party financing service providers (collectively, "Credit Providers"). You may be eligible for financing or payment plan arrangements with one or more of Absolute Dental's affiliated Credit Providers. If you are interested to learn more about financing your dental care at Absolute Dental with credit, you must complete and sign this form. By doing so, you will authorize Absolute Dental to use or disclose certain protected health information about you to determine if you pre-qualify with one or more of Absolute Dental's affiliated Credit Providers.

1. INDIVIDUAL PATIENT CONFIRMING THE AUTHORIZATION

Please provide the following information. If you are completing this form on behalf of the patient whose protected health information is subject to this authorization, please provide the following information about the patient:

Patient Name: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Patient Account Number: _____

2. THE USE AND/OR DISCLOSURE AUTHORIZATION

By signing this form, I voluntarily give my authorization to use or disclose my protected health information (PHI), subject to the following terms and conditions:

PHI Subject to This Authorization: I authorize Absolute Dental to use or disclose the following types of PHI for the purposes described in this form:

- My first, middle, and last name
- My address, including city, state, and zip code
- My phone number(s)
- My email address(es)
- My social security number

Who May Use, Disclose, or Receive My PHI: I authorize Absolute Dental to use or disclose my PHI for the purposes described in this form. I authorize Absolute Dental's affiliated Credit Providers and consumer reporting agencies to use PHI they receive from Absolute Dental for the purposes described in this form.

Purposes of the Use or Disclosure of My PHI: I authorize the use or disclosure of my PHI for the following purposes:

- To permit Absolute Dental, its affiliated Credit Providers, and their business associates to review my credit history to determine if I pre-qualify for financing or payment plan arrangements with any Credit Provider to pay for my dental care at Absolute Dental.
- To permit Absolute Dental and its business associates to send marketing communications to me about financing or payment plan arrangements with any Credit Provider with which I am determined to pre-qualify.

3. ENDING THE AUTHORIZATION

This authorization will end when I cease obtaining my dental care at Absolute Dental. I understand that I may revoke this authorization at any time by giving written notice to Absolute Dental's Privacy Officer. However, I understand that I may not revoke this authorization or any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

4. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

I understand that Absolute Dental does not condition my dental treatment on signing this authorization form. If I do not sign this form, I may continue to receive dental treatment at Absolute Dental without consequence or penalty.

5. POSSIBILITY OF REDISCLOSURE

Although federal privacy laws and regulations require Absolute Dental and its business associates to protect the privacy and security of my PHI, those laws and regulations may not prevent redisclosure of my PHI by other recipient(s) under this authorization or protect the privacy and security of my PHI if such redisclosure were to occur.

6. INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the PHI described in this form with the people and/or organizations named or described in this form. If I am someone other than the patient completing this form, I attest that I am the patient's personal representative and have the legal authority to sign this form on the patient's behalf and authorize the use or disclosure of the patient's PHI as described in this form. All information I have provided in this form is accurate and truthful to the best of my knowledge.

Signature: _____ Date: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name:

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on _____and remains in effect until it is replaced.

1. OUR PLEDGE REGARDING DENTAL INFORMATION

The privacy of your dental information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and service you receive at our dental office. We need this record to provide you with quality care and comply with certain legal requirements. This notice will tell you about the ways we may use and share dental information about you in our organization and with affiliated business entities. We also describe your rights and certain duties we have regarding the use and disclosure of dental information. Throughout this notice we refer to your medial information as dental information.

2. OUR LEGAL DUTY

Law requires us to:

1. Keep your dental information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your dental information.
3. Follow the terms of the current notice
4. Notify you of a breach of your dental information when required by law.

We have the right to:

1. Change the privacy practice and the terms of this notice at any time, provided that the changes are permitted by the law.
2. Make the changes in our privacy practice and the new terms of our notice effective for all dental information that we keep, including information previously created or received before the changes.

Notice of changes to privacy practices:

1. Before we make an important change in our privacy practices we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF DENTAL INFORMATION

The following section describes different ways that we use and disclose dental information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use of disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose dental information. We will not use or disclose your dental information for any purpose not listed below without your written authorization. Most uses and disclosures of your dental information for marketing purposes and disclosures that constitute the sale of dental information will be made only by your written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of the notice.

FOR TREATMENT: We may use dental information about you to provide you with dental treatment or services. We may disclose dental information about you to doctors, nurses, technicians, or other people who are taking care of you. We may also share dental information about you to your other health care providers to assist them on treating you.

FOR PAYMENT: We may use and disclose your dental information for billing, financing payment or collection purposes. A bill may be sent to you or a third party payer or affiliated business associates. The information on or accompanying the bill may include your dental information.

FOR HEALTHCARE OPERATIONS: We may use and disclose your dental information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your dental information for treatment, payment and health care operations, we may use and disclose dental information for the following purposes.

Notification: We may use and disclose dental information to notify or help notify: a family member, your personal representative or another person responsible for your care or payment of your care. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, dental supplies, x-ray or other dental information for you.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of dental information.

Funeral Director, Coroner, Medical Examiner: To help these professionals carry out their duties, we may share the dental information of a person who has died, with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use dental information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for the government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose dental information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances, under limited circumstances, such as court order, warrant, or grand jury subpoena we may share your dental information with law enforcement officials. We may share limited information with a law enforcement official concerning the dental information of a suspect, fugitive, material witness, crime victim or missing person. We may share the dental information of an inmate or other person of lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your dental information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your dental information to person's subject to jurisdiction of the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise to be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose dental information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your dental information if it is necessary to prevent a serious threat to your health or safety or safety of others. We may share dental information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose dental information when authorized or necessary to comply with laws related to workers compensation or other similar programs.

Health Oversight Activities: We may disclose dental information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose dental information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of law enforcement official, reports regarding suspected victims at the request of a law enforcement official reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders and Other Communications: We may use or disclose dental information for purposes of sending you communications, such as appointment confirmations or reminders, including by means of auto-dialed and pre-recorded message calls and SMS messages (including text messages).

Alternative and Additional Dental Services: We may use and disclose dental information to furnish you with information about health related benefits, financing options and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your dental information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You are also entitled to receive and electronic copy of your dental information if maintained electronically in our records. You must make your request in writing. You may get the forms to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact address listed at the end of this notice. If you request copies we will charge you $25.00 and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for full explanation of our fee structure.
2. Receive a list of all the times we or our business associates share your dental information for purpose other than treatment, payment and health care operations and other specific exceptions.
3. Request that we place additional restrictions on our use or disclosure of your dental information. Except as specified in this paragraph, we are not required to agree to these additional restrictions, but we will abide by our agreement (except in the case of an emergency). We are required to agree to your request to restrict disclosures to health plans if the disclosure is for payment or healthcare operations and pertain solely to a healthcare item or service for which you have paid out of pocket in full, except where required by law.
4. Request that we communicate with you about our dental information by different means or to different locations. Your request that we communicate your dental information to you by different means or at different locations must be made in writing to the contact address listed at the end of the notice.
5. Request that we change certain parts of your dental information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name of the change and to include the change in any future sharing of the information.
6. If you have received this form electronically and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact address listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may contact us to submit a complaint or submit request involving any of your rights in section 4 of this notice by writing to the following address: 2250 S. Rancho Drive, Suite 205, Las Vegas, NV 89102

I have read the Notice of Privacy Practices and have been given the opportunity to review it.

Name _____ Birthdate _____

Signature _____ Date _____

PATIENT CONSENT FOR TREATMENT & OFFICE POLICY

Patient Name: _____

Please initial each

INSURANCE & PAYMENT

____As a courtesy to you, we will be happy to submit your dental claims on your behalf. However, filing your dental claim is not a guarantee of payment for the service(s) performed you are still responsible for payment of services. We do not know if or what, your insurance company will pay until the actual claim is submitted and processed. Many plans have exclusions and limitations which will affect your outof-pocket expense. Please understand that our responsibility is to provide you and your family with treatment that best meets your needs and we do not try to match your care to insurance plan limitations or benefits. Our staff will assist you in obtaining maximum dental insurance benefits and will try to verify the coverage that your particular plan provides. It is your responsibility to know your dental benefits. Co-pays and deductibles are due at the time service is provided. If your dental Insurance company payment is not received within 90 days of date of service, the entire balance is due from you. You can then dispute the claim and get reimbursement directly from your Insurance Company. I understand that this treatment plan is ONLY an ESTIMATE of coverage and NOT a guarantee of payment. Any charges not paid by my insurance are my responsibility. Having 2-Insurances may reduce your out of pocket co-pay from your primary insurance, there is no guarantee that charges will be paid in full. You may be eligible for financing or payment plan arrangements and you hereby consent to pre-screening for any such financing arrangements.

UPGRADES

_____I understand that if I elect to have upgrades, I will not hold Absolute Dental responsible for collecting from my insurance since upgrades are NOT a covered benefit. I have been informed of the type of upgrades I have selected.

COMMUNICATIONS

_____I expressly consent to receiving calls and messages, including auto-dialed and pre-recorded message calls, and SMS messages (including text messages) from Absolute Dental, its affiliates, agents, and others calling or communicating at their request or on their behalf, at any telephone numbers that I have provided to Absolute Dental (including any cellular telephone numbers). I understand that such calls and messages may include, but not be limited to, appointment confirmations and reminders, and communications promoting general dental health awareness and treatment options provided by Absolute Dental. I understand that my cellular or mobile telephone provider may charge me for such communications, depending on the type of plan I carry. I understand I may unsubscribe from receiving text messages or calls at any time by replying STOP, STOPALL, UNSUBSCRIBE, CANCEL, END or QUIT to any text message such I receive from Absolute Dental.

APPOINTMENT CANCELLATION/MISSED

_____Last minute cancellations deny other patients the benefit of treatment they need. We appreciate as much notice as possible if you need to change/cancel an appointment. We do understand, occasionally, an emergency will present itself; therefore, you may not be able to cancel your appointment within a reasonable time frame. We kindly request that you cancel your appointment within a 24-hour notice. Patients who are unable to do so will be charged a $25.00 fee for general appointments or $50.00 fee for specialist appointments for cancellations made with less than 24-hour notice. We also reserve the right to discharge any patient due to missed appointments.

_____I the patient or guardian, hereby authorize the provider to perform the procedure(s) or course(s) of treatment listed in the "treatment plan". I understand my dental condition and have discussed several treatment options with the dentist. I have received a copy of the treatment plan".

_____I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

_____I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

_____I authorize the provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed in the "treatment plan". I also give my consent for these individuals to administer any needed medicine and to perform any necessary life-saving procedures.

_____I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I understand that a blood transfusion may be a part of a life-saving procedure and I give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure.

_____I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue.

X_____ X _____

Patient/ Guardian Signature Date Office Staff/ Witness Signature Date

PATIENT CONSENT TO TREATMENT

Patient Name: _____

In reading and signing this form it is understood that ENGLISH is the language that I understand and use to communicate.

Consent exam & X-Rays

(**Initials**)_____

[ ] 1. DRUGS, MEDICATIONS, AND ANESTHESIA:

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, come of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest.

I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of at least twenty-four (24) hours after my release from surgery).

I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia, numbness, and/or irritation of the area of injection.

I understand that if I elect to utilize Nitrous Oxide, "Atarax", Chloral, "Xanax", or any other sedative, possible risks include, but are not limited to; loss of consciousness, obstruction of airway, anaphylactic shock, cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedations. I also understand that someone needs to watch me closely for a period of 8 to 10 hours following my dental appointment, to observe for possible deleterious side effects, such as obstruction of airway.

(**Initials**)_____

[ ] 2. HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS):

I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits.

PERIODONTICS – I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to the loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extractions.

(**Initials**)_____

[ ] 3. REMOVAL OF TEETH:

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time.

Potential risks include, but are not limited to the following:

A. Post-operative discomfort, swelling, prolonged bleeding, tooth sensitivity to hot or cold, gum shrinkage (possibly exposing crown margins), tooth looseness, delayed healing (dry-socket), and/or infection (requiring prescriptions or additional treatment, i.e. surgery).
B. Injury to adjacent teeth, caps, or fillings (requiring the re-cementation of crowns, replacement of fillings, fabrication of crowns, or extraction), or injury to other tissues not within the described surgical area.
C. Limitation of opening, stiffness of facial and/or neck muscles, change in bite, or temporomandibular joint (jaw joint) difficulty (possibility requiring physical therapy or surgery).
D. Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications.
E. Possible bone fracture which may require wiring or surgical treatment.
F. Opening of the maxillary sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
G. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side; this may persist for several weeks, months, or in remote instances, permanently.

(**Initials**)_____

I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.

If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever (s)he may deem advisable, including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility.

(**Initials**)_____

[ ] 4. FILLINGS

I have been advised of the need for fillings, either silver (amalgam) or composite (resin), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and/or crown), which would necessitate a separate charge.

I understand that the silver amalgam restoration is an acceptable material according to the American Dental Association guidelines and, as such, is a treatment used by your dentist. The advantages and disadvantages of alternate materials have been explained to me.

(**Initials**)_____

[ ] 5. ENDODONTIC TREATMENT (ROOT CANAL THERAPY)

The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments, as well as the consequences of non-treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a crown (cap) over the tooth.

I understand that treatment risks can include, but are not limited to the following:

A. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.
B. Post treatment swelling of the gums that are in the vicinity of the treated tooth or facial swelling, either of which may persist for several days longer.
C. Infection.
D. Restricted jaw opening.
E. Breakage of root canal instrument during treatment, which may in the judgement of the doctor be left in the treated root canal or bone as part of the filling material, or it may require surgery for removal.
F. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.
G. Risk of temporary or permanent numbness in treated area.

If an "open and medicate' or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for, and finish final root canal therapy. If root canal treatment is not finalized I expose myself to infection and tooth loss.

If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted.

(**Initials**)_____

[ ] 6. CROWN AND BRIDGE (CAPS):

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy.

I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment.

(**Initials**)_____

[ ] 7. DENTURES – COMPLETE OR PARTIAL:

The problems of wearing dentures have been explained to me including; looseness, soreness, and possible breakage, and relining due to tissue change. Follow-up appointments are an integral part of maintenance and success of prosthetic appliances. Persistent sore spots should be immediately examined by the doctor.

I further understand that surgical intervention (i.e. tori [bone] removal, bone recontouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction.

(**Initials**)_____

[ ] 8. PEDODONTICS (CHILD DENTISTRY):

I understand that the following procedures are routinely used at this dental office, as well as being accepted according to the American Dental Association guidelines.

A. POSITIVE REINFORCEMENT – Rewarding the child who portrays desirable behavior, by use of compliments, praise, a pat or hug, and/or token objects or toys.
B. VOICE CONTROL – the attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
C. PHYSICAL RESTRAINT – Restraining the child's disruptive movements by holding down their hands, upper body, head, and/or legs by use of the dentist's or assistant's hand or arm, or by use of a special device (referred to as a 'papoose board').
D. NITROUS OXIDE and/or ORAL SEDATION – Nitrous Oxide is a mild gas that is mixed with oxygen, and is used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use the parent/guardian must understand that the child should not eat or drink for a period of four hours prior to the sedation appointment. The parent/guardian must be available to escort the child home after the sedation procedure, and observe their behavior throughout the day.

I understand that with the use of an injection, used to numb the tooth area for dental procedures, the possibility exists that the child may inadvertently bite their lip causing injury to occur.

I understand that the need to return to the office for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time.

I understand the need to return to the office within three months following any treatment on a "baby tooth" for evaluation, and the possibility of it then needing an extraction.

(**Initials**)_____

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COPMLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HER/HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAT OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD AN OPPOURTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUATIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

I UNDERSTAND THESE DENTAL SERVICES ARE PROVIDED WITHOUT DISCRIMATION BASED ON RACE, RELIGION, COLOR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTAITON, PHYSICAL OR MENTAL DISABILITY, AGE, OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF IT'S PATIENTS.

Signature: _____ Relationship: _____ Date: _____/_____/_____
(Patient or Legal Representative)

Doctor:_____ Witness: _____