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(800) 243-4675

PATIENT NUMBER

PATIENT'S NAME ____
Last First Initial Date of Birth

I hereby authorize ____
DOCTOR'S NAME

and whomever he/she may designate as his/her assistants, to perform upon me the following operation and/or procedures:

I request and authorize him/her to do whatever he/she deems advisable if any unforeseen condition arises in the course of these designated operations and/or procedures calling, in their judgment, for procedures in addition to or different from those now contemplated.

I consent to the above treatment after having been advised of the risks, advantages and disadvantages of the treatments and the consequences if this treatment were withheld.

I consent to the above treatment plan after having been advised of the alternate plans of treatment available and the known material risks, advantages and disadvantages of the alternative treatment.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration, and thrombophlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my medical condition, contemplated and alternative treatment and procedures, and the risk and potential complications of the contemplated and alternative treatments and procedures, prior to signing this form.

Patient or Guardian's Signature ______________________________ Date ____________

Dentist's Signature ______________________________ Date ____________

Witness's Signature ______________________________ Date ____________

Form No. T243CF

CONSENT FORM

PATIENT NUMBER

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PATIENT'S NAME ______________________________
Last First Initial

I hereby authorize payment directly to ______________________________
of the dental benefits otherwise payable to me. (DENTIST'S NAME)

____
SIGNATURE (INSURED PERSON)

____
DATE

Signature is valid for two years from the above date, unless revoked by me at an earlier date.

____

____
ATTENDING D.D.S. NAME

is authorized to provide any insurance company(s), claim administrator (s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, which ever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

____
PATIENT OR AUTHORIZED PERSON'S SIGNATURE DATE

Form No. T250SF

SIGNATURE ON FILE

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PATIENT NUMBER

PATIENT'S NAME ____
Last First Initial

I ____________________ have had my treatment plan and options explained to me and hereby authorize this treatment to be performed by Dr. ______________________________

Patient's Signature ____ Date ____________
(Parent or Guardian MUST sign if patient is a minor)

I also understand that the cost of this treatment is as follows and that the method of paying for the same will be:

Total (Partial) estimate of treatment $ ____________

Less:

Initial Payment — ____________

Insurance Estimate if Applicable — ____________

Other ____________ — ____________

Balance of Estimate Due $ ____________

Terms: Monthly Payment $ ________ over a ______ month period.

PLEASE CONTACT THE BUSINESS OFFICE IF YOU ARE UNABLE TO MEET YOUR FINANCIAL OBLIGATION

The truth in lending Law enacted in 1969 serves to inform the borrowers and installment purchasers of the true Annual Interest charged on the amounts financed. This law applies to this office whenever the office extends the courtesy of Installment Payments to our patients, even when no finance charge is made.

The signature below indicate a mutual understanding of the ESTIMATE for treatment and the acceptable schedule of payment as noted.

Today's Date ____
Signature of Responsible Party

____
Financial Advisor Phone Number

Note: THIS IS AN ESTIMATE ONLY, if treatment plan should change please request an amended estimate should it not be offered by our staff. This estimate is valid for 90 days from the date above IF treatment has not begun within that period. A patient's voluntary termination of treatment makes this agreement invalid.

Form No. T260FA

FINANCIAL ARRANGEMENTS

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PATIENT NUMBER

PATIENT'S NAME ______________________
Last First Initial

				REASON			
NO.	DATE RECEIVED	DATE SENT	CORRESPONDENCE TO / FROM	INS.	SPEC. REF.	RX	OTHER / COMMENTS
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REFERRAL, INSURANCE, PRESCRIPTION CORRESPONDENCE LOG

Form No. T231CL