GENERAL CONSENT

1. WORK TO BE DONE
   I understand that I am having the following work done: x-rays **(1)Initial________**

2. DRUGS AND MEDICATIONS
   I understand that antibiotics and other medications can cause allergic reactions such as redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.
   (2)Initial________

3. CHANGES IN TREATMENT
   I understand it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions as necessary for the success of my treatment.
   (3)Initial________

4. REMOVAL OF TEETH
   Alternatives to removal of my teeth (Root Canal Therapy, Crowns And Periodontal Surgery, etc.) have been explained to me, and I authorize the dentist to remove the following teeth, __________ as well as others necessary for reasons explained to me. I understand that removing teeth does not always completely remove the infection, if present. I also understand it may be necessary to have further treatment. I understand the risks involved in having teeth removed, including but not limited to: pain, swelling, spread of infection, dry socket, fractured jaw, and the loss of feeling in my teeth, tongue and surrounding tissue (paresthesia) which can last for an indefinite
   period of time. I understand that I may need further treatment by a specialist if complications arise during or following treatment; the cost of which is my responsibility. **Initial________**

5. TEMPORMANDIBULAR JOINT (TMJ)
   I have been informed that my bite is not correct and failure to have my bite properly rehabilitated before any dental procedure might be the cause of possible pain or damage to the teeth, jaw joint, or muscles of the head and neck.
   Initial________

NOTICE OF PRIVACY PRACTICES

Patient Acknowledgment of Receipt

(Patient May Refuse To Sign This Agreement)

This Healthcare Practice recognizes that every patient has the Right of Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information.

By signing this Acknowledgement:
You are only confirming that you have received a copy of our PRIVACY PRACTICES.

You do not give up any of your Rights and you may choose at some point in the future to provide more specific instructions for us to follow regarding your personal health.

I have received a copy of this office's Notice of Privacy Practices:

(4)______________________________ **(5)** ________________ **(6)**______________________________
Signature **Date** **Print Your Name**

______________________________ ______________________________
Signature of Doctor **Signature of Witness**

ASSIGNMENT OF BENEFITS

(7)__________________________________ I hereby instruct and direct **(8)** __________________________________to pay by check
Patient Name **Insurance Company Name**

made out to Q Dental Care and mailed to 3607 E. Bell Road, Suite 5 for the dental expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

(9) ____ **(10)** _______________________
Signature of Policyholder **Date**

PATIENT RESPONSIBILITY

Dear Patient:

You will receive services today with the understanding that in the event your coverage is not effective or benefits are altered, you will be billed and held financially responsible for the services rendered.

(11) ____ **(12)** ____
Patient's Name **Subscriber's Name**

I understand that dentistry is not an exact science and that reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the success of dental treatment, which I have requested and authorized. I understand that no other dentist is responsible for my dental treatment.
I hereby authorize any dentist or dental auxiliaries of Q Dental Care, to proceed with and perform the dental treatments and restorations as explained to me. I understand that this is only an estimate subject to modification due to unforeseen or undiagnosable circumstances that may arise during treatment. I understand that regardless of any dental insurance I may have, I am responsible for all payments of dental fees. If the patient or responsible party defaults in payment, Q dental Care, may exercise all rights and remedies allowed by law, including the right to hold the patient liable for damages, which are, the unpaid balance, collection fees, and possible attorney fees.
I Have Read The Above And Understand My Possible Financial Responsibility To Q Dental Care, And Hereby Affix My Signature As An Acknowledgement Of This Understanding.

(13) ____ **(14)** _______________________
Patient / Guardian Signature **Date**