

PATIENT INFORMATION

NAME: _____ HOME PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SEX:	M	F	DATE OF BIRTH	MON	DAY	YR	AGE	Marital STATUS S M W D	WEIGHT:	HEIGHT:

SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____

EMPLOYER'S NAME: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____

_____ BUS. PHONE: _____

DENTAL INSURANCE:

INSURED PARTY: _____ SOCIAL SECURITY # _____

CARRIER: _____ POLICY: _____

SEND CLAIMS TO: _____

OTHER:

PREVIOUS DENTIST'S NAME & ADDRESS: _____

PHYSICIAN'S NAME & ADDRESS: _____

IN CASE OF EMERGENCY – NOTIFY: _____

RELATIONSHIP TO PATIENT: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

FINANCIAL POLICY:

EMERGENCY CARE – All emergency care patients are expected to pay for their treatment at the end of that visit.

DENTAL INSURANCE – If you have dental insurance, please ask our receptionist for information concerning our policy.

NO DENTAL INSURANCE – Payment is due at the time of service. We accept cash checks, visa and mastercard.

REGISTRATION FORM

Health History Form

ADA American Dental Association®

America's leading advocate for oral health

E-mail: _____ Today's Date: _____

Do you receive texting: Y / N

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: _____ <small>Last First Middle</small>	Home Phone: <i>Include area code</i> ()	Business/Cell Phone: <i>Include area code</i> ()
Address: _____ <small>Mailing address</small>	City: _____	State: _____ Zip: _____
Occupation: _____	Height: _____	Weight: _____ Date of birth: _____ Sex: M F
SS# or Patient ID: _____	Emergency Contact: _____	Relationship: _____ Home Phone: _____ Cell Phone: _____ <small>() () Include area codes</small>

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question) Yes No DK

Active Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3 week duration.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam: _____			
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time? _____			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays: _____			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
What is the reason for your dental visit today? _____							
How do you feel about your smile? _____							

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: _____	Phone: <i>Include area code</i> ()			If yes, what was the illness or problem? _____			
Address/City/State/Zip: _____				Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____			
Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
If yes, what condition is being treated? _____				_____			
Date of last physical exam: _____				_____			

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Do you use controlled substances (drugs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date: _____ If yes, have you had any complications? _____	Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date Treatment began: _____	WOMEN ONLY Are you: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Number of weeks: _____ Taking birth control pills or hormonal replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction. Local anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Codeine or other narcotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Metals _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Latex (rubber) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Iodine _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Hay fever/seasonal _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Animals _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Food _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Artificial (prosthetic) heart valve <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Autoimmune disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Hepatitis, jaundice or liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Previous infective endocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Damaged valves in transplanted heart <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Systemic lupus erythematosus <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Fainting spells or seizures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Congenital heart disease (CHD) Unrepaired, cyanotic CHD <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Neurological disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Repaired (completely) in last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	If yes, specify: _____
Repaired CHD with residual defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Sleep disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.	Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Mental health disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Specify: _____
	Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Recurrent Infections <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Chest pain upon exertion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Type of infection: _____
Cardiovascular disease: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Chronic pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Kidney problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Diabetes Type I or II <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Night sweats <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Arteriosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Eating disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Congestive heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Malnutrition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Persistent swollen glands in neck <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Damaged heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Gastrointestinal disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Severe headaches/migraines <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	G.E. Reflux/persistent heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Severe or rapid weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Sexually transmitted disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Excessive urination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Other congenital heart defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No DK

Name of physician or dentist making recommendation: _____ Phone: _____

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No DK
Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Trinity Dental Designs, Inc.

8532 Old C.R. 54 (Greenbrook Plaza)

New Port Richey, Florida 34653

(727) 372-9669

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____ E-mail: _____
Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies the Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practice, we will issue a revised Notice of Privacy, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting

Contact Person: _____
Telephone Number: _____
E-mail: _____
Address: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

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www.trinitydentaldesigns.com

HIPPA

I, the undersigned, have made aware of my rights as a patient under the "Health Information Portability and Accountability Act" as posted in the office. I further understand that I may request a printed copy of these rights at any time.

MISSED APPOINTMENTS

Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all of our patients. In return, we ask that patients make every effort not to change reserved dental appointments. Broken and missed appointments create scheduling problems for other patients as well as the practice. If you find that you must change your appointment, we require a minimum of 24- hour notice so that we may accommodate another patient. A charge of \$25 will be applied for broken and missed appointments without advanced notification. Appointments longer than 1 hour will have a charge of \$50. Thank you for your cooperation in this matter.

Thank you in advance.

I have read and understand the statement noted above.

Patient/Guardian/Responsible Party _____ Date: _____

Please print your name _____ Date: _____

Published by the American Heart Association The Journal STROKE (1997,28:1724)

Chronic infections such as dental infections or chronic bronchitis may more than double the risk of stroke; the findings are consistent with earlier reports of a link between chronic infections and arteriosclerosis. A study reported at the University of North Carolina showed increased risk of heart disease and stroke in people with periodontal disease.

(Beck, Garcia, Heiss, Offenbacher, Vokonas: J of Periodontology 67:1123, 1996)

People with heart disease or primary cardiac event are now being referred to their Dentists to "get their mouth cleaned up" Patients with frequent bouts of bronchitis in preceding two years have a greater risk for stroke and TIAS. In addition, those with poor dental status, linked to gum disease, were art a 2.6 times greater risk for stroke or TIAS.

Dentists are reporting:

"Before we could tell people to brush and floss or you might lose your teeth."

But now we are saying to brush and floss,

IT COULD SAVE YOUR LIFE."

Informed Consent General Dentistry

Chart # _____

All patients complete 1 thru 4 below, and 5 thru 10 as needed.

1. EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

(Initials _____)

2. DRUGS, MEDICATION AND SEDATION

I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

(Initials _____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(Initials _____)

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

(Initials _____)

5. FILLINGS

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

(Initials _____)

6. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initials _____)

7. CROWNS, BRIDGES, VENEERS AND BONDING

a. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

(Initials _____)

b. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

(Initials _____)

8. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

(Initials _____)

9. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

(Initials _____)

10. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular cleanings as directed, follow a health diet, avoid tobacco products and follow other recommendations. I understand that periodontal disease may have a future adverse affect on the long-term success of dental restorative work.

(Initials _____)

11. BLEACHING

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which will subside when treatment is discontinued. The Dentist may prescribe fluoride treatments for rare cases of persistent sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

(Initials _____)

12. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment.

(Initials _____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature: _____

Date: _____

Doctor: _____

Date: _____