Informed Consent for General Dental Procedures

All patients have the right and responsibility to understand dental treatment recommended by the dentist. Prior to consenting to treatment the dentist will discuss with you the anticipated benefits, commonly known risks, alternative treatments, or the option of no treatment. This will assure that the best possible treatment plan will be developed to fit your needs

We will provide time for you and the dentist to have this discussion so that all of your questions may be addressed.

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.

1. Treatment to be provided I understand that during my course of treatment the following procedures may be needed: diagnostic exams, radiographs, preventive services and restorations.

2. Drugs and medications I understand that all drugs and medications have benefits and side effects. Based on the information I have provided all care will be taken by the dentist to provide me with the best choice of anesthetic, antibiotic or other medication.

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. The dentist will inform me of any new findings or changes that require alteration of my treatment plan.

_____ _____ _____

Print patient name Patient or guardian signature Date

Informed Consent for HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).**
- **Obtaining payment from third party payers (e.g. my insurance company).**

- **Making and reminding you of appointments by telephone, postcards, e-mail and letters**.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosure of my rights under HIPPAA. I understand that I have the right to request restrictions. In addition, I understand that I have the right to allow people to have access to my health information. (Please list names below)

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_____ _____ _____

Print patient name Patient or guardian signature Date