Informed Consent

Potential Risks and Limitations Of Dental Treatment

As a rule, excellent dental results can be achieved with informed and cooperative patients. Thus, the following information is routinely supplied to anyone considering dental treatment in our office recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that dental treatment, like any treatment of the body, has some inherent risks and limitations. These risks and limitations usually do not contra-indicate treatment but should be considered in making the decision to submit to dental treatment.

Perfection is our goal. However, in dealing with human beings, and problems of growth and development, the ravages of dental disease, genetics and patient cooperation, achieving perfection is not always possible. Often a functionally and esthetically adequate result must be accepted. We will do everything within our capacity to insure the best possible care.

Throughout life teeth are constantly changing. Periodic examinations should be made so any disease can be treated promptly. Frequent professional visits are the best insurance against serious dental disease. Decay or gum disease can occur if patients do not brush and floss their teeth properly and thoroughly. Excellent oral hygiene and plaque removal is a must.

On rare occasions the nerve of a tooth may die and become infected. A tooth that has been damaged by deep decay, a minor blow or extensive dental treatment can die over a long period of time. An undetected non-vital tooth may flare up during any dental treatment, and may require endodontics (root canal) treatment to maintain it. It may even have to be removed. There is also a risk that during or following treatment soreness or tenderness may occur in the temporomandibular joints (lower jaw joints).

The total time for treatment can be delayed beyond our estimate. Treatment plans can change due to altered conditions which may surface during treatment. Decay which may appear small on x-ray, may be larger than anticipated resulting in much more extensive treatment.

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I understand that during treatment occasionally any of the above problems may occur. These can include but are not necessarily limited to: pain (discomfort), tooth mobility, tooth decay, devitalization (nerve loss), tooth and/or jaw changes, and injury resulting from the use of high speed dental equipment.

I understand that treatment alternatives will be explained (including the consequences of no treatment) as well as the preferred method of treatment for my mouth. I understand that for a successful result and to lessen the dangers of complication, the following conditions are essential on my part:

1. Excellent oral hygiene
2. Proper diet controls
3. Strict adherence to instructions

4. Cooperation in keeping appointments

I understand that there is no warranty or guarantee to my result and/or care, I also understand that I can, at any time, ask for and receive a full recital of all possible risk related to my treatment.

In addition, I understand that treatment may be discontinued for patients who fail two appointments without prior notification: who are constantly late for their appointments: who continue to excessively cancel their appointments: who fail to practice acceptable oral hygiene: or who are uncooperative with staff providing care.

Signature

Clear

FINANCIAL POLICY AND RELEASE BENEFITS

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Feel free to ask about our fees, Financial Policy, or your responsibility.

IF YOU HAVE INSURANCE

Dental insurance is a contract between you and your insurance company. It is your responsibility to understand the extent and limits of your coverage, and to provide our staff with accurate information to process your claim efficiently (i.e. insurance company address, phone number, etc.). It is not our place to enter into disputes between you and your insurance company regarding deductibles, copayments, etc. other than to provide factual information. We do not directly participate with most Insurance programs; however, as a courtesy, we do process your claim for payment to be made directly to you. Certain conditions may apply to your financial arrangements that may require your authorization for release and assignment of benefits. Your signature below authorizes us to offer this when it applies to your situation. If we do not participate with your insurance, 100% of the total cost is requested at the time of treatment. If you are unable to pay 100%, affordable payment options are available. Our staff will help you process whatever paperwork is required. However, the ultimate responsibility lies with you for payment of any and all monies due.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT

RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize High Plains Perio and Implant Dentistry to release to your benefit program or its representative any information including the diagnosis and the records of any treatment or examination rendered to me. I authorize, if applicable, payment to be sent to High Plains Perio and Implant Dentistry.

Patient Name: Tamara Childers

Signature of Insured

Clear

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED

Medical History

Please enter your medical history details

Physician Name

Physician Phone

Emergency Contact

Emergency Contact Phone

Pharmacy

Allergies

Yes No
Aspirin

Yes No
Codeine

Yes No
Dental Anesthetics

Yes No
Erythromycin

Yes No
Jewelry

Yes No
Latex

Yes No
Metals

Yes No
Penicillin

Yes No
Tetracycline

List any other allergies

Conditions

Yes No
Abnormal Bleeding

Yes No
Alcohol Abuse

Yes No
Allergies

Yes No
Anemia

Yes No

Angina Pectoris
Yes No
Arthritis
Yes No
Artificial Heart Valve
Yes No
Artificial Joint
Yes No
Asthma
Yes No
Blood Transfusion
Yes No
Bruise Easily
Yes No
Cancer-Chemotherapy
Yes No
Colitis
Yes No
Congenital Heart Defect
Yes No
Diabetes
Yes No
Difficulty Breathing
Yes No
Drug Abuse
Yes No
Emphysema
Yes No
Epilepsy
Yes No
Fever Blisters
Yes No
Frequent Headaches
Yes No
Glaucoma
Yes No
HIV+AIDS
Yes No
Hay Fever
Yes No
Heart Attack
Yes No
Heart Surgery
Yes No
Hemophilia
Yes No
Hepatitis A
Yes No
Hepatitis B
Yes No
High Blood Pressure
Yes No
Kidney Problems
Yes No

Liver Disease

Yes No

Low Blood Pressure

Yes No

Mitral Valve Prolapse

Yes No

Osteopor.

Yes No

Pace Maker

Yes No

Pneumocystitis

Yes No

Psychiatric Problems

Yes No

Radiation Therapy

Yes No

Rheumatic Fever

Yes No

Seizures

Yes No

Shingles

Yes No

Sickle Cell Disease

Yes No

Sinus Problems

Yes No

Stroke

Yes No

Thyroid Problems

Yes No

Tuberculosis

Yes No

Ulcers

Yes No

Venereal Disease

Yes No

Yellow Jaundice

Do you use tobacco? Yes No

For women only

Birth Control Yes No

Are you pregnant? Yes No

If so how many weeks? 0

Nursing Yes No

Patient Registration

Please enter the patient's details

First Name *

Middle Name
Optional

Last Name *
Family name

Preferred Name
Nickname

Birth Date
MM/DD/YYYY

SSN
Social Security Number

Sex
Your Gender

Marital Status

Address
The first line of your address

City
City or town

State
State or county

Zip
Zip or postcode

Home Phone
Please include area code

Work Phone - Ext
Please include extension if applicable

Cell Phone

Email
Valid addresses only

Family
Names of previously treated family

Sports/Hobbies

School (if applicable)

School Name

Address
The first line of the address

City
City or town

State
State or county

Zip
Zip or postcode

Responsible Party

If the patient has a responsible party, please enter their details

First Name

Middle Name
Optional

Last Name
Family Name

Birth Date
MM/DD/YYYY

SSN
Social Security Number

Sex
Gender

Marital Status

Home Phone
Please include your area code

Work Phone
Please include extension if applicable

Cell Phone

Address
The first line of your address

City
City or town

State
State or county

Zip
Zip or postcode

Relation To Patient

Email
Valid addresses only

Second Responsible Party

If the patient has a responsible party, please enter their details

First Name

Middle Name
Optional

Last Name
Family Name

Birth Date
MM/DD/YYYY

SSN
Social Security Number

Sex
Gender

Marital Status

Home Phone
Please include your area code

Work Phone
Please include extension if applicable

Cell Phone

Address
The first line of your address

City
City or town

State
State or county

Zip
Zip or postcode

Relation To Patient

Email
Valid addresses only

Signature

Clear

Please list all medications, over the counter and herbal supplements that you take

Patient's Signature

Clear Sign

For Office Use Only

Comments

Dentist's Signature

Clear Sign