BabyTeeth Children's Dentistry

PATIENT CONSENT & AUTHORIZATION FORM

I, the undersigned, _____, have

had the treatment plan(s) for _____ explained to me.

The risks involved with those procedures, alternatives to those procedures, risk therein involved, and the risks of no treatment have also been explained to me and I understand the explanations. I have been given an opportunity to ask questions and have those questions answered.

Based upon these explanations, I have agreed that _____ be treated at BabyTeeth Children's Dentistry, according to the treatment plan and:

a. Authorize the administration of local anesthetic and/or nitrous oxide analgesia deemed necessary for the performance of dental procedures.

b. Authorize the taking of any records, x-rays, or photographs as is deemed necessary in the treatment and the use of such records, x-rays, or photographs by BabyTeeth Children's Dentistry, its doctors, staff, or any other entity authorized by BabyTeeth Children's Dentistry.

c. Acknowledge that all original records and diagnostic aids are the property of BabyTeeth Children's Dentistry. Copies may be furnished upon written request based on established policies of the office. There may be a fee for duplication and/or transfer of records.

d. Grant permission to BabyTeeth Children's Dentistry, its doctors, staff, or any other entity authorized by BabyTeeth Children's Dentistry to reproduce, or use at its sole discretion, any records, x-ray, data, images, or photographs in any form or by any means for the purpose of illustration or publication on, but not limited to, our web site (BabyTeeth Online), in professional journals, or any other type of media. I understand that any and all of such media will be copyrighted property of BabyTeeth Children's Dentistry, its doctors, staff, or other entity authorized by BabyTeeth Children's Dentistry. Whenever possible, data, records, and diagnostic aids used for purposes other than normal outpatient clinical operation will not contain identifying information.

e. I authorize the transmission, electronic or other means, of data for payment or communication purposes including but not limited to insurance companies. I acknowledge I have received and/or reviewed a copy of the Dental Materials Fact Sheet and Patient Privacy Notice.

f. Acknowledge that appointments are scheduled in advance. It is essential, therefore, that all appointments be kept promptly. In the event that an appointment cannot be kept, I will notify BabyTeeth Children's Dentistry at least 2 business days in advance, so that my appointment can be rescheduled or a missed appointment fee may be charged. BabyTeeth Children's Dentistry reserves the right to discontinue treatment if, in its sole opinion, circumstances justify such action. Among reasons for discontinuation of treatment are repeated lateness and failure to keep appointments. I will provide the same courtesy to the office staff and other patients which I expect in return.

Name of Patient: _____

Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____

Relationship: _____ Date: _____