8735 Center Parkway Suite #150, Sacramento, CA 95823 Phone:(916)714-3410 (F):916-714-3510

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Patient Consent Form -- Rights, Rules & Regulations - PLEASE READ & INITIAL

Drug & Medications:
I understand that antibiotic, analgesics and other medication can cause allergic reactions, not limited to redness, swallowing of tissue, pain, itching, vomiting, and /or anaphylactic shocks (severe allergic reaction). **X**________

Changes in treatment plan:
I understand that during treatment, it may be necessary to change or add procedure due to condition found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedure. I give my permission to the dentist to make any/all changes and additions as necessary. **X**________

Removal of teeth:
Alternatives to removal of teeth have been explained to me (root canal treatment, crowns, periodontal surgery, etc.) and I authorized the dentist to remove the recommended teeth and any others necessary due to a change in treatment plan. I understand removing teeth does not always remove all of 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, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia that can last for an indefinite period of time (days, months, or in rare cases permanently) or fracture jaw. I understand 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. I understand that the surgery may cause damage to the area surrounding the site of surgery, such as breakage of a filling, tooth, jaw, soft tissue injury, sinus complications which may include persistent opening into the sinus from the mouth or injury to the temporal mandibular joint (jaw joint) I acknowledge the receipt of and understand the post-op instructions. **X**________

Crowns, Bridges, & Veneers:
I understand sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand I have to wear temporary crowns, which may come off easily, and I must be careful to ensure that they are kept on until the permanent crowns, are delivered. I realize the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size, and color) will be before cementation. I understand if I do not return for my scheduled appointment for delivery of my crown, bridge, or veneer, it may not fit properly, and I will be responsible for any lab fees incurred if a remake becomes necessary. **X**________

Endodontic Treatment (Root Canal):
I realize that is no guarantee that root canal therapy will save my tooth and complications can occur (such as pain or infection). I further realize that occasionally root canal filling material may extend through the root or it may not be responsible to completely fill the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional treatment not limited to surgical procedures may be necessary following root canal treatment (apicoectomy). **X**________

In Office Bleaching:
I understand that ideal patients should be in good health and free of decay and calculus. Yellow staining from aging, tobacco, dark cola, tea, coffee, and red wine will achieve the greatest success from the procedure. I understand those patients with gray shading from tetracycline or other chemicals may experience less traumatic results, but should have some improvement from this brief procedure, for those teeth that have uneven density or white spot originally might not have uniform color with the rest of the teeth. For those patients with severe stains, the use of the ZOOM chair side in combination with take-home products will provide the greatest results in the shortest period of time. I realize that it is very important for all candidates to receive at least an oral prophylaxis depend on patient's oral hygiene condition prior to their tooth whitening appointment. As with any tooth whitening product, ZOOM will not lighten porcelain, composite or any other restorative material. I understand that existing cosmetic dental work may need to be replaced to match the newly whitened teeth, result for whitening process will vary from patient to patient; there is no guarantee prediction on final outcome for cosmetic dentistry. **X**________

Periodontal Loss (Tissue & Bone):
I understand that I have serious condition and my dentist has advised me to have a consultation with periodontist. I understand that not undertaking periodontal treatment may have an adverse effect on my periodontal condition and could lead to loss of some or all of my teeth. **X**________

Dentures – Complete or Partial:
I realize full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me not limited to looseness, soreness, and possible breakage. In case of major bone loss, inadequate arch integrity and/or inadequate soft and hard tissue, severe gag reflex, prognosis will be significantly compromised. I realize that the final opportunity to changes in my new dentures including shape, fit, size placement and color) will be the "teeth in wax" try in visit. I understand most denture require relining approximately three to six months after initial placement and yearly thereafter. The cost of the relines is not included in the initial denture fee. **X**________

I acknowledge receiving the Dental Board of California's Dental Material fact sheet on the date indicated below

- Posted in our lobby is our *Notice of Privacy Practices*. It provides information about how our office may use and disclose your Protected Health Information (PHI). You have the right to review our *Notice of Privacy Practice*s before signing this *Patient Consent Form*. Please take the time to do so now.
- You have the right to request that we restrict how your PHI is used or disclosed for Treatment, Billing/Payment, or Dental Office Operations. *Request for Restriction of PHI* must be submitted to the us in writing and signed by your or as specified in our *Notice*;
- Our office does not have to agree with your *Request for Restriction of PHI*. If we agree to your *Request for Restriction of PHI*, we shall honor that agreement.
- You have the right to revoke this *Patient Consent Form*. Revocation of Consent must be submitted to the us in writing and signed by your as specified in our *Notice*;
- A *Revocation of Consent* does not affect disclosure made prior to the date the *Revocatio*n was made.
- Our *Notice of Privacy Practices* may change from time-to-time. If it does, you will receive a "revised" Notice on the first visit after changes to the *Notice* were made.
- Your signature below signifies your consent to the use and disclosure of your PHI by our office during Treatment, Billing'/Payment, and Dental Office Operation as outlined in our *Notice*.
- Our office may condition dental treatment upon execution of the *Patient Consent Form*.
- This Form is provided to you so that our office may comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I, hereby, sign this consent form to acknowledge understandings of all the above discussed provisions in the patient consent form, including rights, rules, and regulation. I understand that dentistry is not an exact science and that therefore, practitioners cannot guarantee the results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested and authorized. I understand that each dentist is an individual practitioner and is individual responsible for the dental care rendered to me.

Patient signature ____ Date ______________________

Doctor's Signature ____ Date ______________________

Witness (Print Name) ____ Date ______________________

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24 Hour Appointment Cancellation Policy

Perfect Smile Dental Practice has a 24 hour cancellation / rescheduling policy. If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be charged $50.

This policy is in place out of respect for our patients and our staff. Cancellations with less than 24 hour notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

The answer machine does not take the cancellation message. Cancellations must be done over the phone by speaking directly to one of our dental professionals.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Perfect Smile Dental Practice as described above.

Thank you for your understanding and cooperation

Printed Name:___________________________

Signature:_______________________________ Date:________________________________