Printable Dental Forms & Consents

dental intelligence

Thanks for downloading these free dental practice forms from Dental Intelligence!

We hope this packet is a helpful resource for all your patient paperwork needs.

These forms were designed as a template you can use as a starting point. Please be sure to read each form or consent thoroughly and customize as needed to suit your specific practice and policies.*

And if you want an easier way to manage patient paperwork, check out Dental Intelligence Online Dental Forms. Streamline your patient intake with software that detects what forms patients need to complete and automatically sends them a link before their appointment. Patients can securely fill out paperwork from their phone, computer, or tablet prior to their appointment, and completed forms instantly file into your practice management software and update the patient's chart. It's really that easy.

No more scanning, data entry, or forms falling through the cracks. It's more convenient for patients, and your staff will save hours of time each week while improving compliance.

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Schedule a demo

"Dental Intelligence allows us to spend more time with patients and less time in the office with paperwork. Hands down the best program out there!"

-Hilary W., Office Manager

**DISCLAIMER: Dental Intelligence assumes no legal responsibility for any of the forms contained in this free download. These forms were created as a helpful resource and general template for dental practices and should be amended and customized to meet individual practice and provider needs. Forms and consents should be reviewed with your practice's legal consultation to ensure compliance with local and federal laws.*

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New Patient Form

Patient Information

Patient First Name | MI | Patient Last Name | Patient Date of Birth

BASIC INFORMATION

Patient Preferred Name | Patient Gender | SSN #

Marital Status | Referral Source | Referred By

Employer | Occupation

CONTACT INFORMATION

Mobile Phone | Home Phone | Email

ADDRESS INFORMATION

Street Address | City | State | ZIP

EMERGENCY CONTACT

Full Name | Phone Number | Relationship

WORK INFORMATION

Street Address | City | State | ZIP

Patient’s Signature | Date

Doctor’s Signature | Date

Privacy Policy Consent

Clients Rights and HIPAA Authorizations

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 800 5th Ave Ste 101, Seattle, WA 98104:

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as Psychotherapy Notes. All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the clients medical records to maintain a higher standard of protection. Psychotherapy Notes are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individuals medical records. Excluded from the Psychotherapy Notes definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individuals dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's Signature	Date	Doctor's Signature	Date

Financial Policy

Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS

Unless we receive notice of cancellation 48 hours in advance, you will be charged $50. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's Signature	Date	Doctor's Signature	Date

Communication Consents

Email Consent Form

PURPOSE

This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. __________________ offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. __________________ will use reasonable means to protect the security and confidentiality of email information sent and received. However, __________________ cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between __________________ and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by __________________ .

Patient's Signature	Date	Doctor's Signature	Date

Text Message to Mobile Consent Form

PURPOSE

This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. __________________ , offers patients the opportunity to communicate by mobile text messaging Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. __________________ will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, __________________ cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between __________________ and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by __________________.

Patient's Signature	Date	Doctor's Signature	Date

Health History Form

Patient Information

Patient First Name	MI	Patient Last Name	Patient Date of Birth

SUMMARY

Medical Conditions	**none listed**
Allergies	**none listed**
Medications	**none listed**

GENERAL HEALTH INFORMATION

Physician	Physician phone number	Date of last physical exam

Are you presently being treated for any injury or illness? Y N

Have you ever been hospitalized for an injury or illness? Y N

Are you pregnant or planning to become pregnant? Y N

Are you currently breastfeeding? Y N

Are you required to pre-med with antibiotics before dental treatment? Y N

Do you use or have you ever used tobacco? Y N

Do you use alcohol? Y N

Have you ever had an allergic reaction? Y N

MEDICAL CONDITIONS

Do you have a history or are currently being treated for any Digestive conditions? Y N

Do you have a history or are currently being treated for any Lung or Breathing conditions? Y N

Do you have a history or are currently being treated for any Heart or Circulatory conditions? Y N

Do you have a history or are currently being treated for any Autoimmune conditions? Y N

Do you have a history or are currently being treated for any Neurological conditions? Y N

Head or neck injuries? Y N

Condition	Y	N
Artificial Joint	Y	N
High cholesterol?	Y	N
History of cancer?	Y	N
Tumor or abnormal growth?	Y	N
Radiation Therapy?	Y	N
Chemotherapy?	Y	N
HIV / AIDS?	Y	N
Osteoporosis / osteopenia?	Y	N
Type I or Type II diabetes?	Y	N
Anemia?	Y	N
Kidney disease?	Y	N
Liver disease?	Y	N
Thyroid disease?	Y	N
Tuberculosis / measles / chicken pox?	Y	N

Any other medical conditions we should know of?

MEDICATIONS

Question	Y	N
Are you taking any pain medications?	Y	N
Are you taking any Antidepressants or Anxiety medications?	Y	N
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?	Y	N
Are you taking any Allergy or Asthma medications?	Y	N
Are you taking any Antibiotics?	Y	N
Are you currently taking any other medications or dietary supplements?	Y	N

Patient's Signature

Date

Doctor's Signature

Date

Dental History Form

Patient Information

Patient First Name	MI	Patient Last Name	Patient Date of Birth

General Information

Who was your previous Dentist and how long were you a patient there?

Date of your last dental exam

Do you have any immediate concerns you'd like us to address?

Date of your last cleaning

Office Relationship

What do you value most in your dental visits?

Is there anything you prefer during your visits to make you more comfortable during your time with us?

On a scale from 1-5, 5 being most terrified, are you fearful of dental treatment?

Personal History

Please answer the following questions

Question	Y	N
Are you concerned about the appearance of your teeth?		
Have you had any cavities within the past 2 years?		
Are you interested in improving your smile?		
Do you clench your teeth in the daytime?		
Are any teeth currently sensitive to biting, sweets, hot, or cold?		
Do you avoid or have difficulty chewing or biting heavily any hard foods?		
Do you bite your nails, chew gum or on pens, hold nails with your teeth, or any other oral habits?		
Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea?		

Do you have any problems sleeping, wake up with a headache or with sore or sensitive teeth? Y N

Have you ever noticed a consistently unpleasant taste or odor in your mouth? Y N

Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often? Y N

Dental Structural History

Please answer the following questions

Do your gums bleed when brushing or flossing? Y N

Is brushing or flossing typically painful? Y N

Have you ever experienced or been told you have gum recession? Y N

Have you ever been treated for or been told you have gum disease? Y N

Have you had any teeth removed for braces or otherwise? Y N

Do you know of any missing teeth or teeth that have never developed? Y N

Have you ever had braces, orthodontic treatment or spacers, or had a “bite adjustment?” Y N

Are your teeth becoming more crowded, overlapped, or “crooked?” Y N

Are your teeth developing spaces? Y N

Do you frequently get food caught between any teeth? Y N

Have you noticed your teeth becoming shorter, thinner, or flatter over the years? Y N

Is it often difficult to open wide? Y N

Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?) Y N

Do you have more than one bite? Or do you notice shifting your jaw around to make your teeth fit together? Y N

Patient’s Signature	Date	Doctor’s Signature	Date

Dental Insurance Information

Patient Information

Patient First Name | MI | Patient Last Name | Patient Date of Birth

Primary Insurance Information

Do you have a dental insurance? Y N

In order to provide the best possible dental service to you and your family, ______________ offers a wide choice of dental membership plans.

Would you like to learn more about our in-house membership plan? Y N

Policy Holder Information

Patient's relationship to the insurance holder: Self | Spouse | Child | Other

Policy Holder's Name

Policy Holder's Date of Birth

Policy Holder's SSN

Policy Holder's Address

Policy Holder's City

Policy Holder's State

Policy Holder's ZIP

Policy Holder's Phone Number

Policy Holder's Employer

Dental Insurance Company

ID Number

Group Number

Phone number on the back of your insurance card

Address on the back of your insurance card

Secondary Insurance Information

If you would like to add secondary insurance, you need to provide primary insurance first.

Do you have a secondary dental insurance? Y N

Patient's relationship to the Insurance Holder

Policy Holder's Name

Policy Holder's Date of Birth

Policy Holder's SSN

Policy Holder's Address

Policy Holder's City

Policy Holder's State

Policy Holder's ZIP

Policy Holder's Phone Number

Policy Holder's Employer

Dental Insurance Company

ID Number

Group Number

Phone number on the back of your insurance card

Address on the back of your insurance card

Infant Assessment Form

Patient Information

Patient First Name

MI

Patient Last Name

Patient Date of Birth

HEALTHCARE PROVIDER

Child's Physician/Pediatrician

Pediatrician's Address

Physician/Pediatrician Phone Number

Lactation Consultant

Lactation Consultant's phone number

BASIC INFORMATION

Gender

Weight

Height

Which hospital was your infant born in?

DELIVERY METHOD

- Vaginal Birth ☐
- C-Section Birth ☐

Baby is currently being fed by (select all that apply):

- Breast milk at the breast only ☐
- Breast milk with a shield ☐
- Formula or donor milk in SNS or other supplementation system ☐
- Breast milk with an SNS or other supplementation system ☐
- Breast milk in bottle ☐
- Formula or donor milk in bottle ☐

How long does baby take to eat?

How often does baby eat?

MEDICAL CONDITIONS

Is your child currently being treated for, or has a history of any medical conditions? Y N

Select all that apply:

- ADD/ADHD
- AIDS/HIV
- Anemia
- Anxiety disorder
- Arthritis
- Asthma
- Autism
- Bleeding/transfusions
- Blood dyscrasias
- Cancer/tumors
- Cerebral palsy
- Cleft lip/palate
- Congenital birth defects
- Diabetes
- Sickle cell disease/trait
- Significant injuries
- Tonsil/adenoid problems
- Tuberculosis

Select all that apply:

- Endocrine/growth
- Eyesight
- Frequent infections
- Heart Disease
- Heart murmur
- Hepatitis
- Kidney disease
- Liver/GI disease
- Mental delays
- Personality/social disorder
- Physical delays
- Recurrent headaches
- Recurrent herpes/fever blisters
- Rheumatic fever
- Seizures
- Speech/hearing
- Spina bifida
- Other

If other, please specify:

Were there any difficulties at birth? Y N

If yes, provide details here

MEDICAL HISTORY

Was your infant premature? Y N

If yes, by how many weeks?

Has your infant had any surgery? Y N

If yes, provide details here

Infants are usually given vitamin K at birth. Did your child receive the vitamin K shot? Y N Unk

If yes, provide details here

Does your infant have any bleeding disorders? Y N

If yes, provide details here

Does your infant have any heart disease? Y N

If yes, provide details here

HAS YOUR INFANT EXPERIENCED ANY OF THE FOLLOWING?

Shallow latch at breast or bottle Y N

If yes, provide details here

Hiccups often Y N

If yes, provide details here

Falls asleep while eating Y N

If yes, provide details here

Lip curls under when nursing or taking bottle Y N

If yes, provide details here

Slides or pops on and off the nipple Y N

If yes, provide details here

Thrush Y N

If yes, provide details here

Colic symptoms / Cries a lot Y N

If yes, provide details here

Gumming or chewing nipple when nursing Y N

If yes, provide details here

Reflux symptoms Y N

If yes, provide details here

Clicking or smacking noises when eating Y N

Amount / Frequency

Gassy (toots a lot) / Fussy often Y N

If yes, provide details here

Poor weight gain Y N

If yes, provide details here

Nose congested often Y N

If yes, provide details here

Baby is frustrated at the breast or bottle Y N

If yes, provide details here

Short sleeping requiring feedings every 1-2hrs Y N

If yes, provide details here

Snoring, noisy breathing or mouth breathing Y N

If yes, provide details here

Gagging, choking, coughing when eating Y N

If yes, provide details here

Feels like a full time job just to feed baby Y N

If yes, provide details here

Milk dribbles out of mouth when nursing/ bottle Y N

If yes, provide details here

Pacifier falls out easily, doesn't like, won't stay in Y N

If yes, provide details here

Has your infant had a prior surgery to correct the tongue or lip tie? Y N

If yes, when, where, and by whom?

Is your child currently taking any medications? Y N

If yes, provide medications, dosages and reason

MOMS MEDICAL HISTORY

Shallow latch at breast or bottle Y N

If yes, provide details here

Bleeding nipples Y N

If yes, provide details here

Lipstick shaped nipples Y N

If yes, provide details here

Poor or incomplete breast drainage Y N

If yes, provide details here

Blistered or cut nipples Y N

If yes, provide details here

Infected nipples or breasts Y N

If yes, provide details here

Plugged ducts / engorgement / mastitis Y N

If yes, provide details here

Baby prefers one side over other Y N

Left or Right?

Using a nipple shield Y N

If yes, provide details here

Nipple thrush Y N

If yes, provide details here

Pain on a scale of 1-10 when first latching?

Pain (1-10) during nursing?

Additional information you would like us to be aware of?

Parent/Guardian's Signature

Date

Doctor's Signature

Date

HIPAA - Release of Information Authorization Form

Patient Information

Patient First Name | MI | Patient Last Name | Patient Date of Birth

HIPAA - Release of Information Authorization Form

In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), must first be authorized. Authorization includes the signature of the individual authorizing the release of their information. Information will not be available to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the childs consent.

I want to provide the authorization ☐ Y ☐ N

INFORMATION REGARDING PERSON AUTHORIZING RELEASING HIS/HER INFORMATION

Name of Person Authorizing Release | Date of Birth Person Authorizing Release

PERSONAL INFORMATION TO BE RELEASED

- Dental and/or medical services claim information ☐
- Prescription, diagnostic, treatment, and/or care management service ☐
- Reviews required by HHS or HIPAA – compliant healthcare operations ☐
- Other ☐

If other, please specify:

THE ABOVE INFORMATION MAY BE RELEASED AND/OR RECEIVED BY

Email ☐ Phone ☐ Fax ☐ Mail ☐

The following is an authorization allowing ________________ to release information to whomever you designate. ________________ is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of person/organization that the office may release my information to

Relation of person/organization that the office may release information to

Phone number of person/organization that the office may release information to

I want to add a second person/organization Y N

Name of person/organization that the office may release my information to

Relation of person/organization that the office may release information to

Phone number of person/organization that the office may release information to

I want to add a third person/organization Y N

Name of person/organization that the office may release my information to

Relation of person/organization that the office may release information to

Phone number of person/organization that the office may release information to

I WANT THIS CONSENT TO

Continue Indefinitely

Effective Only Until

If effective only until, please specify:

Consent

I understand that consent may be revoked by me at any time in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practices Notice of Privacy Practices.

Patient's Signature	Date	Doctor's Signature	Date

Guardian Authorization Form

Patient Information

Patient First Name | MI | Patient Last Name | Patient Date of Birth

Authorizations

I authorize the person listed below to accompany my child, to his/her dental appointment.

Authorized Person's Name | Relation to Patient

I agree to the following to be performed in my absence:

Procedure	Y	N
Examination	Y	N
Radiographs (x-rays) deemed necessary	Y	N
Cleaning	Y	N
Fluoride	Y	N
Silver Diamine Fluoride	Y	N
Necessary restoration of decayed teeth	Y	N
Nitrous Oxide (laughing gas)	Y	N
Extractions	Y	N
Emergency treatment as necessary	Y	N

Guardian Authorization Consent

I request that I be contacted at the phone number below if treatment needs or recommendations change during treatment. If treatment recommendations change during treatment and I am not able to be reached I authorize the person accompanying my child to make an informed decision and authorize ______________ to perform the necessary and recommended treatment. I understand this guardian authorization will remain in effect until revoked in writing.

Legal Guardian's/Parent's Signature | Date | Contact Number

Release of Records Authorization Form

Patient Information

Patient First Name	MI	Patient Last Name	Patient Date of Birth

Informed Consent Information

The purpose of this document is to provide written information regarding the risks, benefits, and alternatives to the procedure named above. This material serves as a supplement to the discussion you have with __________. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask __________ prior to signing the consent form.

Release from Another Provider

Previous Dentist's Name/Practice Name	Previous Dentist's Address

Previous Dentist's Phone Number	Previous Dentist's Email Address

PLEASE SEND A COPY OF:

- [ ] All my dental records
- [ ] Dental x-rays
- [ ] Other

Release to Another Provider

New Dentist's Name/Practice Name	New Dentist's Address

New Dentist's Phone Number	New Dentist's Email Address

PLEASE SEND A COPY OF:

- [ ] All my dental records
- [ ] Dental x-rays
- [ ] Other

Consent

By signing below, I consent for my dental treatment records and/or x-rays to be transferred by email to ________________.

Practice Name:

Practice Address:

Practice Phone number:

Patient's Signature	Date	Doctor's Signature	Date

Gum Disease Risk Assessment

Patient Information

Patient First Name	MI	Patient Last Name	Patient Date of Birth

General Health Information

In our practice, we strive to provide our patients with optimal oral health. We are focused on preventing or limiting periodontal (gum) disease, and dedicated to identifying and treating disease early, when the pain and costs associated with treatment are much less. According to the National Center for Biotechnology Information, "Significant associations between periodontal disease and cardiovascular disease, diabetes mellitus, preterm low birth weight, and osteoporosis have been discovered, bridging the once-wide gap between medicine and dentistry." Please take a few minutes to answer the questions below so that we can assess your individual risk for gum disease and tailor our treatment recommendations to your specific needs.

Question	Y	N
Do you floss daily?		
Are you age 35 or older?		
Do you have a family history of premature adult tooth loss and/or gum disease?		
Do you have a history of heart disease and/or are you taking medication for hypertension?		
Are you taking medication for diabetes?		
Have you ever been a tobacco user (including smokeless tobacco) and/or smoker of any kind (including marijuana/vape)?		
Is there redness on toothbrush or in the sink when you rinse after brushing?		
Do you have persistent bad breath (noticed by you, your partner/friend/colleague)?		
Have you noticed a movement/shifting of teeth (gaps developing, tooth/teeth mobility)?		
Do you occasionally experience discomfort/pain when eating/chewing?		

TOTAL POINTS

Assessing your Gum Disease Risk

LOW TO MODERATE RISK: Total Points 0-3

MODERATE TO HIGH RISK: Total Points 4-9

HIGH RISK: Total Points 10 or higher

Patient's Signature	Date	Doctor's Signature	Date

Treatment Refusal

Patient Information

Patient First Name	MI	Patient Last Name	Patient Date of Birth

Informed Treatment Refusal

DATE OF TREATMENT PLAN PROPOSED: ______________________________

RECOMMENDED TREATMENT: ____

- I have been provided with the appropriate information and this refusal form so that I may fully understand the treatment recommended for me and the consequences of my refusal to proceed with dental treatment at this time.
- I have been presented with enough information to make an informed decision regarding my proposed treatment plan with ___________.
- I have had the opportunity to ask any questions regarding the risks that may occur if I do not proceed with the recommended treatment.
- I understand the importance of the recommended treatment, any other alternative treatment options (if available), the risks of dental treatment, and my refusal of care.

Consent

I acknowledge that I have fully read this document and have a complete understanding of the importance of the treatment recommended. I personally assume any and all risks and consequences of my refusal. I release ________________________ from all liability or ill effects which may result from my refusal to move forward with the proposed dental treatment plan.

Patient's Signature	Date	Doctor's Signature	Date

Consent for General Dentistry

Patient Information

Patient First Name	MI	Patient Last Name	Patient Date of Birth

Informed Consent Information

- **Examination and X-Rays**
  I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.
- **Local Anesthesia**
  Anesthetizing agents are injected into a small area or injected as a nerve block directly into a larger area of the mouth with the intent of numbing the area to receive dental treatment. Risks include but are not limited to infection, swelling, allergic reactions, hematoma, bruising, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek/tongue/lip biting can occur from the injection. It is normal for the numbness to take time to wear off after treatment, usually 2-3 hours. However, it can take longer, and rarely the numbness is permanent if the nerve is injured.
- **Drugs, Medications & Sedation**
  I have been informed and understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and/or a 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 to me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may increase risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.
- **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 my teeth that were not discovered during the examination. The most common being root canal therapy following routine restorative procedures. I give my permission to ___________ to make any changes and additions as necessary.
- **Temporomandibular Joint Dysfunctions (TMJ)**
  I understand that symptoms of popping, clicking, locking, and pain can intensify or develop in the joints of the lower jaw(near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ 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.
- **Fillings**
  I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage, and tooth sensitivity is a common after-effect of newly placed fillings.
- **Removal of Teeth (Extraction)**
  I understand removing teeth does not always remove all 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 and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue(paraesthesia) that can last for an indefinite period of time or a 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.

- **Crowns, Bridges, Veneers, and Bonding**
  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 to my new crown, bridge, or cap(including shape, fit, size, placement, and color) will be done before cementation after which additional fees may apply. It has been explained to me that in 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.
- **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 but not limited to looseness, soreness, and possible breakage. I realize that the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be a "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement and the cost of relining is not included in the initial denture fee.
- **Endodontic Treatment (Root Canal)** I realize there is no guarantee that root canal treatment will save my tooth. I realize that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment(apicoectomy).
- **Periodontal Treatment** I understand periodontitis(gum disease) is 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, includingnon-surgical cleaning, gum surgery and/or extractions. I understand the success of treatment depends in part on my efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products, and follow other recommendations.

Consent

I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that no guarantees of results or absolute satisfaction are possible with dental treatment. I have truthfully answered all questions about my medical history and present health condition fully and truthfully. I have told ____________________ or other office personnel about all conditions, including allergies, which might indicate that I should receive oral medications and/or anti-anxiety agents. I will not hold ____________________ or associates responsible for any errors or omissions I may have made. I also understand if I ever have any changes in health status or in medication(s), I need to inform the doctor at the next appointment. I authorize ____________________to forward a review of findings and/or any other necessary dental information to the referring doctor for his/her records, as well as any third parties such as insurance companies who may request information. I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All of my questions have been answered by ____________________ in a satisfactory manner and I believe I have all of the necessary information to give informed consent for treatment. I further understand that this consent shall remain in effect until terminated by me.

Patient's Signature	Date	Doctor's Signature	Date

Consent for Intravenous Sedation

Patient Information

Patient First Name	MI	Patient Last Name	Patient Date of Birth

Informed Consent Information

The purpose of this document is to provide written information regarding the risks, benefits, and alternatives to the procedure named above. This material serves as a supplement to the discussion you have with ___________. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask ___________ prior to signing the consent form.

THE PROCEDURE

Intravenous Conscious Sedation utilizes the placement of an IV to administer small doses of various medications to produce a state of relaxation, reduced perception of pain, and drowsiness. I understand that I will not be put to sleep as I would with a general anesthetic. In addition, local anesthetics will be administered to numb the areas of my mouth to be operated on and thus further control the pain. I understand that the drugs to be used may include Versed, Demerol, and Phenergan. The purpose of this document is to ensure that you understand intravenous conscious sedation and consent to its use during your dental treatment. Please read each item carefully.

I understand that the purpose of intravenous conscious sedation is to more comfortably receive necessary dental treatment and that it has limitations and risks, and its absolute success cannot be guaranteed.

I understand that intravenous conscious sedation is a drug-induced state of reduced awareness and may decrease my ability to respond. The sedative will not put me to sleep and I will be capable of responding during the procedure. My ability to respond normally will return when the effects of the sedative wear off.

SEDATION ALTERNATIVES

I understand that the alternatives to intravenous conscious sedation are:

- **No sedation:** Treatment is performed using a local anesthetic, and the patient is fully aware of surrounding activity.
- **Anxiolytics:** A sedative pill is taken prior to treatment to reduce anxiety and fear.
- **Nitrous Oxide sedation:** Provides relaxation through inhalation of the gas, and the patient is still generally aware of surrounding activity. Its effects are rapidly reversed with the administration of oxygen.
- **General anesthesia:** Generally used in a hospital setting, it requires breathing to be supported and the patient has no awareness of his surroundings.

RISKS

I have been informed that there are risks and limitations to all dental procedures. Additionally, with the use of intravenous sedation, the following risks are also present:

- Taking an inadequate dosage of my sedation medications, may require undergoing the procedure without full sedation, or having to reschedule the procedure.
- The inability to discuss treatment options during the procedure should the circumstance arise, which requires ___________ to change the treatment plan.

- Inadequate sedation with the initial dosage may require the patient to undergo the procedure without full sedation or delay the procedure for another time.
- Atypical reaction to sedative drugs which may require emergency medical attention and/or hospitalization such as altered mental states, physical reactions, allergic reactions, heart attack, brain damage, and/or death.

AUTHORIZATION

If my treating doctor deems a change in treatment is deemed absolutely necessary, I authorize ___________ to proceed with it. I also understand that I have the right to designate another individual to discuss any changes in treatment with ___________ on my behalf.

I authorize ______________________________ to make the decision on my behalf to change my treatment plan as advised by ___________.

PRE-SEDATION INSTRUCTIONS

I understand and agree that I have informed ___________ of and/or agree to the following:

- I am not pregnant or breastfeeding.
- I have disclosed all medications and supplements that I currently take.
- I have disclosed any known allergies.
- I am of sound mental and physical ability to make the decision to use intravenous conscious sedation, and I understand what it is and what it is not.
- I will not consume alcohol within 24 hours of using intravenous conscious sedation.
- I understand that I will not be able to drive or operate machinery for 24 hours after completion of my treatment.
- I have made arrangements for transportation to and from my scheduled appointment, and for a responsible adult to stay with me for 12 hours following any appointments during which I have been sedated.

Consent

By signing below, I attest that I have provided as accurate and complete medical and personal history as possible, including antibiotics, drugs, or other medications I am currently taking, as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me. I confirm that in spite of the possible complications and risks, I elect to undergo conscious sedation with ___________. I acknowledge that there can be no guarantees concerning the results or effects of sedation. ___________ has explained conscious sedation and what it is for, how this could help me, and also reviewed the associated risks and complications. ___________ has explained to me the alternative sedation options that might be done instead, and what would happen if I decline this procedure, and has answered all of my questions to my satisfaction. I have been offered the opportunity to read the consent form. I hereby give my consent to proceed with conscious sedation.

Patient's Signature	Date	Doctor's Signature	Date

Consent for Nitrous Oxide

Patient Information

Patient First Name	MI	Patient Last Name	Patient Date of Birth

Informed Consent Information

The purpose of this document is to provide written information regarding the risks, benefits and alternatives of the procedures named above. This material serves as a supplement to the discussion you have with ___________. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask ___________ prior to signing the consent form.

THE PROCEDURE

Nitrous oxide/oxygen inhalation is a mild form of conscious sedation used alongside local anesthetic to calm an anxious patient during a dental procedure. ___________ has recommended that you be given nitrous oxide/oxygen (laughing gas) to breathe during dental treatment to help reduce fear and apprehension. Nitrous oxide/oxygen is a blend of the two gases oxygen and nitrous oxide. When inhaled, it is absorbed by the body and has a calming effect. Normal breathing eliminates nitrous oxide/oxygen from the body. When breathing nitrous oxide/oxygen, you will smell a sweet pleasant aroma and experience a sense of well-being. If you are worried by the sights, sounds, or sensations of dental treatment, you may respond more positively with the use of nitrous oxide/oxygen.

SAFETY PRECAUTIONS

Women who are or might be pregnant will not be allowed to enter the treatment room during any procedure where nitrous oxide is used. This is not a negotiable policy as we will not assume the risk of exposure to your unborn baby under any circumstances. Nitrous oxide/oxygen is very safe, perhaps the safest sedative in dentistry. It is nonaddictive. It is mild, easily taken, and quickly eliminated by the body. You will remain fully conscious and in full awareness and control of your natural reflexes, when breathing nitrous oxide/oxygen.

BENEFITS

- Reduce or eliminate dental anxiety.
- Enhance positive communication and patient cooperation throughout the dental procedure.
- Increase tolerance of longer appointments or multiple procedures.
- Raise the pain-reaction threshold and reduce untoward movements in reaction to the procedure.
- Allow mentally/physically disabled, or medically compromised patients to successfully undergo complex dental procedures.
- Reduces the gag reflex.

RISKS

Known risks of breathing nitrous oxide include, but are not limited to:

- Headache and/or slight disorientation
- Nausea and vomiting
- Behavior in some autistic patients can be negatively affected
- Recent nasal congestion may prevent nitrous oxide from being effective

CONTRAINDICATIONS

If you have any of the following medical concerns, please alert the doctor right away to discuss if you should be treated with nitrous oxide:

- Autism spectrum
- Pregnant
- MTHFR diagnosis in the patient or immediate family
- Risk factors for B12/folate deficiency
- Malabsorption pernicious anemia
- Atrophic gastritis
- Gastrectomy
- Whipple's disease
- Ileal resection
- Crohn's disease
- Prolonged antacid use
- Intestinal bacterial overgrowth
- Intestinal parasites

Consent

I understand that nitrous oxide sedation may not be covered by my insurance company. It is my responsibility to verify coverage prior to my appointment. If this procedure is not covered, I will accept responsibility for the fee. I further understand that using nitrous oxide sedation does not guarantee that dental treatment can be provided successfully. I understand that I am responsible for the nitrous oxide fee, even if dental treatment cannot be completed due to a lack of cooperation.

By signing below, I consent and agree that ___________________ has explained how this treatment could help me, and also provided me the associated risks and complications. _______________ has explained to me the alternative treatments that might be done instead, and what would happen if I decline to undergo this procedure. __________________ has answered all of my questions to my satisfaction. I have been offered the opportunity to read the consent form. I hereby give my consent to have this treatment/procedure performed.

Patient's Signature	Date	Doctor's Signature	Date

Consent for Oral Conscious Sedation

Patient Information

Patient First Name	MI	Patient Last Name	Patient Date of Birth

Informed Consent Information

The purpose of this document is to provide written information regarding the risks, benefits, and alternatives to the procedure named above. This material serves as a supplement to the discussion you have with ___________. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask ___________ prior to signing the consent form.

THE PROCEDURE

Oral conscious sedation utilizes the elective administration of an oral sedative medication during dental procedures to reduce the fear and anxiety related to the experience. The purpose of this document is to ensure that you understand oral conscious sedation and consent to its use during your dental treatment. Please read each item carefully.

- I understand that the purpose of oral conscious sedation is to allow more comfort while receiving necessary dental treatment and that it has limitations and risks, and its absolute success cannot be guaranteed.
- I understand that oral conscious sedation is a drug-induced state of reduced awareness and may decrease my ability to respond. The sedative will not put me to sleep and I will be capable of responding during the procedure. My ability to respond normally will return when the effects of the sedative wear off.
- I understand that the sedative prescribed will be two pills (Triazolam & Benadryl) and a liquid (Hydroxyzine HCl) that I will take at my scheduled appointment. The effects of this sedative will last approximately 16-20 hours, but the exact length of time varies by the individual and can exceed this estimate.

SEDATION ALTERNATIVES

I understand that the alternatives to oral conscious sedation are:

- **No sedation:** Treatment is performed using a local anesthetic, and the patient is fully aware of their surroundings.
- **Anxiolytics:** A sedative pill is taken prior to treatment to reduce anxiety and fear.
- **Nitrous Oxide sedation:** Provides relaxation through inhalation of the gas, and the patient is still generally aware of their surroundings. Its effects are rapidly reversed with the administration of oxygen.
- **Intravenous sedation:** The slow injection or drip of a sedative into a vein.
- **General anesthesia:** Generally used in a hospital setting, requires breathing to be supported and the patient has no awareness of their surroundings. (Not offered in this office)

RISKS

I have been informed that there are risks and limitations to all dental procedures. Additionally, with the use of oral sedation, the following risks are also present:

- Taking an inadequate dosage of my sedation medications, which may require undergoing the procedure without full sedation, or having to reschedule the procedure.
- The inability to discuss treatment options during the procedure should any circumstance arise that requires ___________ to change the treatment plan.

- Inadequate sedation with initial dosage may require the patient to undergo the procedure without full sedation or delay the procedure for another time.
- Atypical reaction to sedative drugs which may require emergency medical attention and/or hospitalization such as altered mental states, physical reactions, allergic reactions, heart attack, brain damage, and/or death. Reduces the gag reflex.

AUTHORIZATION

If __________ deems a change in treatment is deemed absolutely necessary, I authorize __________ to proceed with it. I also understand that I have the right to designate another individual to discuss any changes in treatment with __________ on my behalf.

I authorize ____________________________ to make the decision on my behalf to change my treatment plan as advised by __________.

PRE-SEDATION INSTRUCTIONS AND CONFIRMATIONS

I understand and agree that I have informed __________ of and/or agree to the following:

- I am not pregnant or breastfeeding.
- I have disclosed all medications and supplements that I currently take.
- I have disclosed any known allergies.
- I am of sound mental and physical ability to make the decision to use oral conscious sedation, and I understand what it is and what it is not.
- I will not consume alcohol within 24 hours (before or after) of being given oral conscious sedation medications.
- I understand that I will not be able to drive or operate machinery for 24 hours after completion of my treatment.
- I have made arrangements for transportation to and from my scheduled appointment and for a responsible adult to stay with me for 12 hours following any appointments during which I have been sedated.

Consent

By signing below, I attest that I have provided a complete medical and personal history as accurately as possible, including antibiotics, drugs, or other medications I am currently taking, as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me. I confirm that in spite of the possible complications and risks, I elect to undergo conscious sedation with __________. I acknowledge that there can be no guarantees concerning the results or effects of sedation. __________ has explained conscious sedation and what it is for, how this could help me, and also reviewed the associated risks and complications. __________ has explained to me the alternative sedation options that might be done instead, and what might happen if I decline this procedure. __________ has answered all of my questions to my satisfaction. I have been offered the opportunity to read the consent form. I hereby give my consent to proceed with conscious sedation.

Patient's Signature	Date	Doctor's Signature	Date

In-House Membership Savings Plan Sign-up

Patient Information

Patient First Name	MI	Patient Last Name	Patient Date of Birth

In-House Membership Dental Savings Plan

Our dental savings plan is designed to provide greater access to quality dental care at an affordable price. We provide discounts on our fee schedule which means that you can save on routine cleanings, necessary care, and elective treatments.

BENEFITS OF A DENTAL SAVINGS PLAN

- No yearly max to the discounts offered
- No deductible
- No worrying about insurance coverage
- No claim forms
- No waiting periods
- No exclusions
- No one will be denied coverage

PLAN INCLUDES

- Two regular exams
- One emergency exam
- Two Professional cleanings (in absence of gum disease)
- Two oral cancer screening exams
- Check-up X-rays as needed throughout the year
- Up to 20% OFF of most treatments**
- Two Fluoride treatments for patients age 18 and under

PLAN ACTUAL COST

- Individual plan: $______
- Child Plan* (Age 18 and Under): $______
- Family Plan:
  - Two Members: $______
  - Three Members: $______
  - Four Members: $______
  - $______ per additional member

*Child plan is valid only with family members living under the same roof and children ages 18 and under.

**Discounted services (______________________________% of the normal rate) for fillings and core build up, periodontal treatments, crowns and bridges, cosmetic work (veneers, whitening), root canals, night guards, dentures and partials, implant restorations, and extractions.

Terms and Conditions

ELIGIBILITY

- This program is a dental savings discount plan, not dental insurance.
- To be an independent member, you must be 18 years or older. Eligible dependents include your spouse or domestic partner and your children under age 26.
- This plan cannot be combined with any other dental insurance.
- This plan cannot be combined with any other offers.
- If the patient elects to use dental insurance, insurance plan fees, payments and deductibles will apply.
- All patients are subject to office policies.

PAYMENTS

- The enrollment fee must be paid in full at the time of enrollment to receive discounts. A payment plan
- CANNOT be used for enrollment fees.
- All payments for treatments must be paid in full at the time of service to receive a discount. Any services that
- are not paid in full at the time of service will be billed at our regular fees.
- All payments are non-refundable.
- No refunds will be given if a member does not use the plan benefits, relocates, or obtain dental insurance.
- 12 months term begins the day you sign-up

EXCLUSIONS

- Plans and fees are subject to change yearly.
- No discount is provided for services requiring referral to a specialist. Specialist referral is at the discretion of the doctor.
- Should treatment is needed following an injury or 3rd party outside insurance is involved, this discount cannot be used.
- Treatment initiated prior to enrollment is not eligible for discounts.
- Prosthesis delivered or in progress treatment completed more than 60 days after the termination of coverage is not eligible for discount.
- Treatment fees are guaranteed for 90 days from the date quoted by the office.
- Plan doesn't offer any orthodontic or specialist treatments

Two no-shows or cancellations without 48 business hours notice may lead to you being dropped from the program without any refund. If you choose to extend your payment for paying through a third party financing company, the treatment discount will be reduced to ______________________ due to merchant fees. Dental products are not included.

Consent

I have read and understand the rules and regulations.

Patient's Signature	Date	Doctor's Signature	Date

Media Consent Form

Patient Information

Patient First Name	MI	Patient Last Name	Patient Date of Birth

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

AUTHORIZATION

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

PURPOSE

The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising

REVOCABILITY

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

NO TREATMENT CONDITIONS

I understand that the practice cannot condition treatment on whether or not I sign this authorization.

Patient's Signature	Date	Doctor's Signature	Date