GENERAL CONSENT

1. WORK TO BE DONE
   I understand that I am having the following work done: x-rays **(1)Initial_____**

2. DRUGS AND MEDICATIONS
   I understand that antibiotics and other medications can cause allergic reactions such as redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.
   (2)Initial_____

3. CHANGES IN TREATMENT
   I understand it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions as necessary for the success of my treatment.
   (3)Initial_____

4. REMOVAL OF TEETH
   Alternatives to removal of my teeth (Root Canal Therapy, Crowns And Periodontal Surgery, etc.) have been explained to me, and I authorize the dentist to remove the following teeth, _____ as well as others necessary for reasons explained to me. I understand that removing teeth does not always completely remove the infection, if present. I also understand it may be necessary to have further treatment. I understand the risks involved in having teeth removed, including but not limited to: pain, swelling, spread of infection, dry socket, fractured jaw, and the loss of feeling in my teeth, tongue and surrounding tissue (paresthesia) which can last for an indefinite
   period of time. I understand that I may need further treatment by a specialist if complications arise during or following treatment; the cost of which is my responsibility. **Initial_____**

5. TEMPORMANDIBULAR JOINT (TMJ)
   I have been informed that my bite is not correct and failure to have my bite properly rehabilitated before any dental procedure might be the cause of possible pain or damage to the teeth, jaw joint, or muscles of the head and neck.
   Initial_____

NOTICE OF PRIVACY PRACTICES

Patient Acknowledgment of Receipt

(Patient May Refuse To Sign This Agreement)

This Healthcare Practice recognizes that every patient has the Right of Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information.

By signing this Acknowledgement:
You are only confirming that you have received a copy of our PRIVACY PRACTICES.

You do not give up any of your Rights and you may choose at some point in the future to provide more specific instructions for us to follow regarding your personal health.

I have received a copy of this office's Notice of Privacy Practices:

(4)_____ **(5)** _____ **(6)**_____

Signature **Date** **Print Your Name**

_____ _____

Signature of Doctor **Signature of Witness**