Legacy Smile Family Dental

NEW PATIENT CONSENT FORM
And FINANCIAL POLICY

EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. (Initials_____)

DRUGS AND MEDICATION

I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic (severe allergic reactions). I have informed the Dentist of any known allergies. They may cause drowsiness, 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 care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). (Initials_____)

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 the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials_____)

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD 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 treatments, the cost of which is my responsibility. (Initials_____)

CONSENT TO TREAT: if you have dental insurance, we want you to receive the full benefit of it. Our office staffs will assist you completing your insurance forms and verifying coverage that your particular insurance plan provides. We accept assignment of your insurance payment, another service to you (certain restrictions may apply i.e. secondary insurance). You are responsible for any applicable deductible amount and the portion that your insurance does not cover. Please be advised that although our office will make every effort to accurately estimate what your insurance may pay, this does not, in any anyway, guarantee actual payment from your insurance company. You will be financially responsible remember that the contact is between you and your insurance we only assist you submit your dental claim out of courtesy. We are committed to rendering the best treatment of care according to the patient's needs and we do not allow insurance to dictate what these may be.

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, which may be indicated in connection with rendering appropriate dental care and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior treatment, a full explanation of the procedure(s) involved will be given by the doctor and/or staff. I agree to pay for all services rendered by this office. I also consent to the use of periodic appointment reminder phone calls and appointment items send via e-mail or mail. I also understand that should my account become delinquent, my information may be release to third party collection agency to assist with collecting of fees associated with treatment rendered in this office.

To the best of my knowledge, all the preceding "Patient Information" and health history answers are true and correct. I also understand that it is my responsibility to inform the office of any changes to my medical history prior to all appointments.

If an appointment is not cancelled at least 24 hours in advance a $25.00 fee will be charged, note that this will not be covered by the insurance.

I hereby attest that I have read the above section and understand it completely.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Witness Signature