Advanced Dental Arts, LLC
Geoffrey C. Riley, DDS

DENTAL TREATMENT CONSENT FORM

For your convenience, we make available this generalized dental consent form for your review and signature. Please do not hesitate to ask our dental staff any questions you may have.

DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

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.

REMOVAL OF TEETH

If the teeth are savable/restorable, the alternatives to removal of teeth are root canal therapy, crowns, and periodontal surgery, etc. I understand removing teeth does not always remove all 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 jaw. I understand 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 AND BRIDGES

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 the final opportunity to make changes in my new crown or bridge (including shape, fit, size, and color) will be the “teeth in wax” try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure 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, and 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 the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

PERIODONTAL LOSS (TISSUE & BONE)

I understand that serious gum problems can lead to bone infection or bone loss and that it can lead to the loss of my teeth. Alternative treatments include gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

I understand dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for my minor child or myself. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

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THANK YOU FOR BEING A PATIENT IN OUR PRACTICE!

In order to provide our patients with the best treatment and keep the cost of treatment reasonable, we have found it necessary to review our financial policy. The following is a statement of our financial policy. We require you to read, agree, and sign prior to any treatment.

A.) Patients with insurance are required to pay their deductible and estimated co-payment at time of treatment. We are more than happy to assist you with filing of your insurance. However, keep in mind figures given are only an estimate. You will be responsible for any account balance left unpaid by insurance.

B.) We accept Visa, MasterCard, and Discover

C.) Care Credit offers financing with accepted credit application. They offer payment plans up to 6 months.

D.) There is a $25.00 returned check fee

E.) Once your appointment has been reserved for you, we ask a minimum 48 hour notice of cancellation. This courtesy on your part will make it possible to care for others in need of dental treatment. Please note there will be a fee of $50.00 per hour for appointments broken without the minimum requested notice.

I, _____, have read, understand, and agree to the above policy. I understand I am fully responsible for the fees of service rendered, regardless of any insurance I may have.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Advanced Dental Arts, LLC
Geoffrey C. Riley, DDS

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

*Obtain payment from third-party payers

*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices, and I may contact the office at any time to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name: _____

Relationship to Patient: _____

Signature: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Reason: _____

Initials: _____