

# Healthy Smiles Family Dentistry

## *Request and Consent for Dental Treatment*

Please initial following line, by initialing; you signify you fully understand the statement and or office policies. I request and authorize Drs. A. Shah, A. Desai, M. Shah, assistants, and dental hygienists to perform treatment.

\_\_\_\_\_ I fully disclose all health problems, including but not limited to: heart conditions, high/low blood pressure, diabetes, need for antibiotics prior to dental treatment, (due to prosthetic valves, joints or heart condition) medication taken/prescribed, bleeding problems and allergies.

Signature of person consenting for treatment: I have sufficient opportunity to discuss the treatment plan, the benefits to be reasonably expected from this treatment, as well as the alternative approaches, including no treatment. All of my questions have been answered to my satisfaction, and I consent to the treatment and procedures prescribed.

**I confirm I have read this form or it was read to me.**

Patient name: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

## *Notice of Privacy Practices*

**Purpose:** this form is used to obtain acknowledgement of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, \_\_\_\_\_, understand that a copy of the HIPPA Regulation has been made available to me to read in the office and is posted in the reception area of the office for me to view at any time. I understand that it is my right to have, and the office has offered me, a copy of my own to take with me if I so desire.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_