NEW PATIENT REGISTRATION

Lindale Dental
CARE | COMFORT | CONVENIENCE

PATIENT REGISTRATION

First Name | Last Name | Middle Initial

Patient is:

☐ Responsible Party (Parent/Legal Guardian) ☐ Policy Holder

PATIENT INFORMATION

Address: | City,State,Zip

Home Phone: | Work Phone: | Cell Phone:

Sex:
○ Male ○ Female

Marital Status
○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date

Social Security Number | Drivers License | Email

Referred By:

Employment Status
○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status
○ Full Time ○ Part Time

Confidential & Emergency Contact information

Emergency Contact Number | Emergency Relation to Patient | Emergency Phone

○ Emergency Contact ○ Discuss Treatment ○ Consent for Treatment ○ Release Record
○ Add additional emergency contact(s) ○ I do not want to add an emergency contact

Will you be paying out of pocket?
○ Yes ○ No

Are you using Medicaid/CHIP?
○ Yes ○ No

PRIMARY INSURANCE INFORMATION

Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Name of Insured | Member ID

Insured Social Security Number | Insured Birth Date

Employer | Insurance Company

Emp. Phone Number | Ins. Phone Number

MEDICAL HISTORY

Lindale Dental
CARE | COMFORT | CONVENIENCE

Patient Name

Birth Date

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions

Are you under a physician's care now?
Yes No

If yes, please explain. If no, please type N/A below

Have you ever been hospitalized or had a major operation?
Yes No

If yes, please explain. If no, please type N/A below

Have you ever had a serious head or neck injury?
Yes No

If yes, please explain. If no, please type N/A below

Are you taking any medications, pills, or drugs?
Yes No

If yes, please explain. If no, please type N/A below

Gender
Male Female Other

Do you take, or have you taken, Phen-Fen or Redux?
Yes No

Do you take, or have you taken a bisphosphonate (anit-bone resorption medication)
Yes No

Are you on a special diet?
Yes No

Do you use tobacco?
Yes No

Do you use controlled substances?
Yes No

Do you need to pre-medicate?
Yes No

If yes, please explain. If no, please type N/A below

Are you allergic to any of the following?
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

If yes, please explain. If no, please type N/A below

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No

Alzheimer's Disease ○ Yes ○ No

Anaphylaxis ○ Yes ○ No

Anemia ○ Yes ○ No

Angina ○ Yes ○ No

Arthritis/Gout ○ Yes ○ No

Artificial Heart Valve ○ Yes ○ No

Artificial Joint ○ Yes ○ No

Asthma ○ Yes ○ No

Blood Disease ○ Yes ○ No

Blood Transfusion ○ Yes ○ No

Breathing Problem ○ Yes ○ No

Bruise Easily ○ Yes ○ No

Cancer ○ Yes ○ No

Chemotherapy ○ Yes ○ No

Chest Pains ○ Yes ○ No

Cold Sores/Fever Blisters ○ Yes ○ No

Congenital Heart Disorder ○ Yes ○ No

Convulsions ○ Yes ○ No

Cortisone Medicine ○ Yes ○ No

Diabetes ○ Yes ○ No

Drug Addiction ○ Yes ○ No

Easily Winded ○ Yes ○ No

Emphysema ○ Yes ○ No

Epilepsy or Seizures ○ Yes ○ No

Excessive Bleeding ○ Yes ○ No

Excessive Thirst ○ Yes ○ No

Fainting Spells/Dizziness ○ Yes ○ No

Frequent Cough ○ Yes ○ No

Frequent Diarrhea ○ Yes ○ No

Frequent Headaches ○ Yes ○ No

Genital Herpes ○ Yes ○ No

Glaucoma ○ Yes ○ No

Hay Fever ○ Yes ○ No

Heart Attack/Failure ○ Yes ○ No

Heart Murmur ○ Yes ○ No

Heart Pacemaker ○ Yes ○ No

Heart Trouble/Disease ○ Yes ○ No

Hemophilia ○ Yes ○ No

Hepatitis A ○ Yes ○ No

Hepatitis B or C ○ Yes ○ No

Herpes ○ Yes ○ No

High Blood Pressure ○ Yes ○ No

Hives or Rash ○ Yes ○ No

Hypoglycemia ○ Yes ○ No

Irregular Heartbeat ○ Yes ○ No

Kidney Problems ○ Yes ○ No

Leukemia ○ Yes ○ No

Liver Disease ○ Yes ○ No

Low Blood Pressure ○ Yes ○ No

Lung Disease ○ Yes ○ No

Mitral Valve Prolapse ○ Yes ○ No

Pain in Jaw Joints ○ Yes ○ No

Parathyroid Disease ○ Yes ○ No

Psychiatric Care ○ Yes ○ No

Radiation Treatments ○ Yes ○ No

Recent Weight Loss ○ Yes ○ No

Renal Dialysis ○ Yes ○ No

Rheumatic Fever ○ Yes ○ No

Rheumatism ○ Yes ○ No

Scarlet Fever ○ Yes ○ No

Shingles ○ Yes ○ No

Sickle Cell Disease ○ Yes ○ No

Sinus Trouble ○ Yes ○ No

Spina Bifida ○ Yes ○ No

Stomach/Intestinal Disease ○ Yes ○ No

Stroke ○ Yes ○ No

Swelling of Limbs ○ Yes ○ No

Thyroid Disease ○ Yes ○ No

Tonsillitis ○ Yes ○ No

Tuberculosis ○ Yes ○ No

Tumors or Growths ○ Yes ○ No

Ulcers ○ Yes ○ No

Venereal Disease ○ Yes ○ No

Yellow Jaundice ○ Yes ○ No

Osteoporosis ○ Yes ○ No

○ No to all medical conditions

Have you ever had any serious illness not listed above?

Yes No

If yes, please explain. If no, please type N/A below

Comments

Signature of Patient, Parent or Guardian

Date

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA

Lindale Dental
CARE | COMFORT | CONVENIENCE

ACKNOWLEDGEMENT RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

("ACKNOWLEDGEMENT")

I acknowledge that I have received a copy of this Dental Practice's HIPAA NOTICE OF PRIVACY

Patient Name

Who is the person signing this form?

- The patient
- Someone else

Please Note: It is your right to refuse to sign this Acknowledgement

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy, but it could not be obtained because:

- An emergency prevented us from obtaining acknowledgement
- A communication barrier prevented us from obtaning acknowledgement
- The individual was unwilling to sign
- Other

If other, please list

Staff Member Signature

HIPPA NOTICE OF PRIVACY PRACTICES

Lindale Dental
CARE | COMFORT | CONVENIENCE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Rosharon Smiles

II. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and controls your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on January 2022.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other healthcare professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and healthcare professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text, or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called,“business associates”) that perform functions on our behalf or provide us with services if the information is necessary for such functions orservices. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls, and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect, or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect, or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful processes that are not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for law enforcement purposes, such as to identify or locate a suspect, material witness, or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners, and Funeral Directors. We may disclose your health information to a coroner, medical examiner, or funeral director to allow them to carry out their duties.

8. Organ, Eye, and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank, or transplant cadaveric organs, eyes, or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone’s health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illnesses.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If the use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in the format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or another format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict the use of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means, and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, and health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by firstclass mail within sixty (60) days of the event. A breach occurs when there has been unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol, and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you upon request. The effective date of this Notice is 01/01/2017.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

Patient Name

Relation to patient

Signature

Date

APPOINTMENT POLICY

Lindale Dental
CARE | COMFORT | CONVENIENCE

In our unwavering dedication to providing exceptional dental services, we prioritize your well-being and satisfaction. Our appointment policy is designed to ensure a seamless and considerate experience for all our valued patients. Please take a moment to familiarize yourself with the details outlined below, so we can continue to serve you with the highest level of care, comfort, and convenience.

Cancellation or Rescheduling:

- I understand that I am required to contact the office 24 hours before my scheduled appointment if I need to cancel or reschedule. This consideration allows for the extension of prompt care to other patients in need.

Broken Appointment Fee for PPO or Cash Patients:

- I acknowledge that as a PPO or cash-paying patient, failing to provide the required 24-hour notice for appointment changes may result in a $15 broken appointment fee.

Missed Appointments for Medicaid Patients:

- I am aware that insurance providers for Medicaid patients will automatically receive notifications for any missed appointments without proper cancellation or rescheduling.

Important Consideration: After the Third No-Show:

- I acknowledge that after the third instance of not showing up for a scheduled appointment without notice, there may be a discussion regarding my continued participation in the practice.

Copayment Collection for Proposed Treatment:

- For Monday through Friday appointments, I understand that 25% of my copayment for the proposed treatment will be collected at the time I schedule my next appointment.
- For Saturday appointments, I acknowledge that 50% of my copayment for the proposed treatment will be collected at the time I schedule my appointment.

Copayment Collection for Proposed Treatment:

- For Monday through Friday appointments, I understand that 25% of my copayment for the proposed treatment will be collected at the time I schedule my next appointment.
- For Saturday appointments, I acknowledge that 50% of my copayment for the proposed treatment will be collected at the time I schedule my appointment.

Your understanding and cooperation in adhering to these guidelines are vital in maintaining the excellence of our healthcare services. If you have any questions or require further clarification, our dedicated team is here to assist you. Thank you for your unwavering commitment to a positive and efficient healthcare experience.

Patient/Legal Guardian Signature

Date

FINANCIAL POLICY CONSENT FORM (UPDATED)

Lindale Dental
CARE | COMFORT | CONVENIENCE

We welcome you and your family to Lindale Dental. We look forward to providing you with top notch quality dental care at affordable prices. To provide you with the most beneficial and comprehensive service and care, we request you to review and complete our office and financial policy consent form. We will be happy to answer any questions you may have regading the proposed treatment and available financial options. We strive to keep informed and involved with your treatment as much as possible.

You need to be aware that:

- We will always do our best to help you to maximize your benefits.
- Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a part to that contract.
- Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

- Our staff is trained to help you with questions you may have retating to how your claim was filed, or regarding any additional information you carrier may need to process your claim. Please, ask if you have any questions
- As a courtesy to all of our insured patients, we will file your dental insurance claim forms. In special circumstances, a particular insurance company's benefit check can be sent to our office directly. In such cases, you are responsible at the time of treatment for payment to us of any applicable deductible and for your co-insurance portion. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately, and benefits are expected are to be paid within 30-45 days. The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 60 days, the unpaid portion will automatically become "self-pay" and a statement will be issued to you for the unpaid portion. You are responsible for any other amounts yours insurance company chooses not to pay for whatever reason.

Please feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with a letter which would include all pertinent information which you may sign and mail. I understand and accept the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction.

I agree to pay for all treatment in a timely fashion as described.

Refund Policy

All payments collected on date of service may be refunded same day. Refunds requested after date of service will be processed within 15 days of refund submission form. Please note ALL PENDING INSURANCE CLAIMS must be paid by your insurance company before a refund may be made.

[For patients with dental insurance who would prefer their insurance Company send payment to the office]

I hereby authorize my insurance benefits to be paid directly to Lindale Dental. I realize that I am responsible to pay for any deductible amount(s), my co insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance, and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient/Legal Guardian First Name

Patient/Legal Guardian Last Name

Patient/Legal Guardian Signature

Date

Lindale Dental
CARE | COMFORT | CONVENIENCE

Informed Consent for Dental Treatment

Patient Name:_____ Date of Birth _____

X-rays:
Proposed treatment: taking of intraoral (inside the mouth) and extraoral (outside the mouth) radiographs.
Benefits of treatment: taking x-rays enables us to view dental cavities, abnormalities, development and eruption of teeth. They are also necessary for proper diagnosis and evaluation purposes.
Alternatives of treatment: none; limited visual examination.
Common Risks: minimal radiation exposure to soft and hard tissues of the head.
Consequences of not performing the treatment: missed diagnosis, possible loss of tooth/teeth

Cleaning (prophylaxis):
Proposed treatment: involves thorough cleaning of teeth to help heal inflamed or infected gum tissue. It involves removal of soft plaque build-up and harder calculus deposits above and below the gum line.
Benefits of treatment: healthy oral environment; also, reduction/elimination of bleeding, odor and periodontal disease.
Alternatives of treatment: referrals for periodontal (gum) surgery according to the severity of condition.
Common risks: bleeding, soreness, swelling, infection of tissue, hot and cold sensitivity, stiff or sore jaw joint.
Consequences of not performing the treatment: discontinued or interrupted treatment could result into further inflammation and infection of gum tissues, lead to tooth decay, and deterioration of surrounding bone structure which could lead to tooth loss.

Anesthetic:
Proposed treatment: injection of anesthetic to surrounding oral tissues.
Benefits of treatment: numbness of tissue and muscle surrounding area of treatment to eliminate pain sensation.
Alternatives to treatment: dental restorations performed with no anesthetic resulting in severe sensitivity and pain.
Common risks: allergic reaction, irritation to nerve tissue, stiff or sore jaw joint, swelling of tissue, bruising and may cause temporary or permanent paralysis.
Consequences of not performing the treatment: severe pain and sensitivity.

Fillings:
Proposed treatment: to remove dental caries and replace with filling material to regain proper tooth anatomy.

Benefits of treatment: restore tooth structure for proper function.
Alternatives of treatment: temporary filling, crown, extraction.
Common risks: allergic to filling material, tooth sensitivity, filling may come out.
Consequences of not performing the treatment: further spread of decay, requiring root canal treatment or severe destruction resulting in tooth loss.

Amalgam (Silver) VS. Composite (Tooth Color):

Amalgam advantages include; Strong, can stand up to biting force, cost effective, resistance to further decay is high, risk of sensitivity is lower, long lasting.
Disadvantages include; less attractive than tooth color alternatives, placement may require removal of healthy tooth structure, corrosion may darken the appearance.

Composite advantages include; Color and shade can be matched to the teeth, permits preservation of as much tooth structure as possible, frequency of repair is low.
Disadvantages include; Can break or wear out quicker than silver, more expensive, may leak over time requiring replacement, can create sensitivity to cold.

Root Canal Treatment/ Pulpotomy:
Proposed treatment: to remove infected pulp tissue and replace with root canal filling material.
Benefits of treatment: eliminate pain, infection, swelling and further destruction of tooth structure.
Alternatives of treatment: extraction.
Common risks: recurrence of symptoms, breakdown of tooth structure.
Consequences of not performing the treatment: increase in severity of pain, swelling, infection, and possible hospitalization and rare instances death.

Crown and Bridge:
Proposed treatment: to strengthen a tooth damaged by decay or previous restoration, and protect a tooth that has had root canal treatment. Improve the biting surface, appearance of damaged, discolored, poorly spaced and/or missing teeth.
Benefits of treatment: to restore or improve the appearance and strength of teeth.
Alternatives of treatment: extraction or Orthodontic treatment (only in proper spacing, not damaged teeth).
Common risks: irritation to surrounding tissue, inflammation, irritation to nerve tissue, stiff or sore jaw joint, sensitivity to hot and cold, also possible root canal treatment.
Consequences of not performing the treatment: further destruction, nerve exposure, loss of tooth function, root canal treatment.
Tooth Extraction:
Proposed treatment: complete removal of a tooth from the mouth
Benefits of treatment: to relieve symptoms and/or permit further planned treatment
Alternatives of treatment: depending on individual treatment needs: root canal treatment, periodontal therapy, crown or filling, no treatment

Lindale Dental

CARE | COMFORT | CONVENIENCE

Common Risks: as with any surgical procedure; discomfort, bleeding, swelling, possible damage to adjacent teeth and/or soft tissue, transient numbness of the jaw **Consequences of not performing the treatment:** increase in severity of pain, swelling, infection, and possible hospitalization and rare instances death.

I have read and understood the entire information on this consent form, which includes x-rays, cleaning, anesthetic, fillings, root canal treatment, crown and bridge, tooth extraction and dental implants. All my questions were answered to my full understanding and satisfaction. I have discussed treatment alternatives, risks, outcomes, and costs with my dentist and have had all of my questions answered before making a decision.

Further, I understand that dentistry is not an exact science and that there are no guaranteed results. Unless otherwise provided by law, I understand that I am responsible for payment of all dental fees not paid in full by any insurance or other applicable coverage. Having had adequate time to reflect upon the alternatives, I consent to the treatment, subject to changes in the treatment plan.

_____	_____
Patient/ Parent / Guardian Printed Name	Relationship to Patient
_____	_____
Patient/ Parent/ Guardian Signature	Date
_____	_____
Witness Printed Name	Witness Signature

HOW DID YOU KNOW ABOUT US?

How did you hear about us?

- Direct Mail/Flyer
- Insurance Company
- Facebook
- News Paper
- Google
- Community Event
- School Event and/or Presentation
- Billboard
- Friends/Family
- Doctor
- Drive by
- Other

If other, please explain

List Doctor, Newspaper, Insurance Company, Friend or Family, that recomment you

Any other strategies you recommend to help spread awareness?