Rawlins County Dental Clinic

Consent for Dental Treatment

Patient's Name: _____ Date of birth: _____

1. I hereby authorize the Dentist at Rawlins County Dental Clinic and/or other such persons as he/she may appoint to perform any necessary dental; procedures as deemed appropriate as part of the dental treatment.
2. I understand that Dental treatment may include examination, prophylaxis, restorations, Endodontics, x-rays, surgery and extractions for the purpose of maintaining, improving and/or restoring soft and hard tissue to a healthy state.
3. I hereby authorize and request dentists at Rawlins County Dental Clinic and/or such designees or assistants as may be selected by him, to perform the following procedure as per dentist's treatment plan.
4. I understand that the risks involved in the above described treatment or procedure(s) include but are not limited to bleeding, swelling, and sensitivity.
5. I understand that unforeseen conditions or circumstances may arise during the course of treatment: hence, I consent to and authorize the performance of any care, procedure or treatment not specified above that the dentist reasonably believes necessary or available as a result of unforeseen events.
6. Additionally, I consent to the administration of any local anesthetic that the dentist deems necessary. I understand that the risks involved with the administration of local anesthetics include but are not limited to: nerve injury, and stiffness of the jaw (trismus).
7. It has been explained to me the option of not using local anesthetic for my treatment.
8. I confirm that I have had the opportunity to ask any questions regarding the patient's care at the dental office and that all such questions (if any) have been answered fully and satisfactorily.
9. I certify that I have read this document and understand its contents. I acknowledge that dental treatment, associated risks and related dental education materials have been explained to my satisfaction.
10. This consent will remain in effect until I choose to terminate it.

I have read and understand the above:

Patient/Representative Signature: X_____Date:_____

ASSIGNMENT, RELEASE, & FINANCIAL RESPONSIBILITY

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
And assign directly to Dr. Roger T. Minneman/Dr. Kristi S. Melcher/Rawlins County Dental Clinic all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance including Medicaid.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature in all insurance submissions.

X_____

Responsible Party Signature Relationship Date

Notice of Privacy Practices- Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

X_____

Patient Name Signature Date

_____

Witness Date