Health Questionnaire Acknowledgment and Consent to Proceed

I, _____ certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify my dental provider of any changes at any subsequent appointment.

I authorize Integrated Dental Care, LLC and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I do voluntarily assume any and all possible risks, including the risk of substantial an serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I understand that placement of restorations may render the involved teeth sensitive to hot and cold temperatures and/or pressure for an extended period of time.

I also consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

_____

Signature of Patient, Legal Guardian, or Authorized Agent of Patient

_____ _____

Relation to Patient Date