

PATIENT'S NAME _____

CONSENT TO PROCEED:

I authorize Dr. K. John Liddiard D.M.D. and/or such associates or assistants as he may designate to perform those procedures as may be necessary or advisable to maintain my dental health or any minor or other individual for which I have responsibility, including but not limited to nitrous oxide, general anesthesia, and all those related to restorative, palliative, therapeutic, or surgical treatment. I understand that the administration of local anesthetic may cause an outward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or not be achieved, for my benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me and I have been given the opportunity to ask questions.

HIPPA - Health Insurance Portability Accountability Act:

We will use your protected health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize coordination between hygienist, dental assistant, dentist, and office staff. We may share you information with physicians, referring dentists, clinical and dental laboratories, or pharmacies. We may use your information to collect payment for treatment you receive in our office. Your health information may be used during performance evaluations of our staff. We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. We may notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. Because we believe regular care is very important to your oral and general health, it will be necessary to use your information to contact you regarding your treatment, including scheduling, follow-up care and reminder calls.

Signature of Patient or Legal Guardian
(Parent, legal guardian or authorized agent of patient)

Date