PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Paladin Dental

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

PALADIN DENTAL

2747 W. Bullard Avenue, Suite 103

Fresno, CA 93711

Patient Financial Agreement

Welcome to Paladin Dental,

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality of dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, *our relationship is with you, our patient, not with your insurance company.* Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract.

As a courtesy to you we will help you process all your insurance claims. Our office require that you complete the "Assignment of Benefits Agreement" that will direct your insurance company to pay your benefits directly to our office. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, VISA, and American Express. Additional financing is available through Care Credit upon request and approval. If payment from your insurance company is not received *in our office* within 60 days from the date of service, it is your responsibility to pay our office for services rendered.

Return checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

PRINT NAME

SIGNATURE DATE

~TO ALL PATIENTS~

This letter is to inform you of our "NO SHOW" policy. You may or may not have already signed this policy, if you have no, we are asking that you sign and date the policy below and return it to our office as soon as possible. If you have signed a "NO SHOW" policy in the past, we are having you sign another policy as we are re-wording our policy to read as follows:

As many of you know, most doctors' offices require a 24-hour cancellation of appointment notice. It is our office policy that if you have an appointment, and fail to notify us of our cancellation 24 hours in advance, you will be charged for that particular visit. You will be charged $25 for the first missed appointment. After three missed appointments we will not book any further appointments for you. The reason for this is that we reserve this time especially for you and if you do not show up, another patient cannot use that time. We do not overbook or double up on patients. This policy is effective September 1, 2017.

I understand that if I miss a scheduled appointment, and do not cancel 24 hours in advance, I will be charged for the missed appointment. I agree to comply with this office policy set forth by my care provider. I will promptly pay this charge upon my next visit. Thank you.

Signature:_____Date:_____

PALADIN DENTAL

2747 W. Bullard Avenue, Suite 103

Fresno, CA 93711

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of Paladin Dental's Notice of Privacy Practices. In this notice, I was advised of how health information about me may be used and disclosed by Paladin Dental. I was also advised how I may obtain a copy of this information and correct errors in my health information.

*Print Name of Patient:*_____ *Patient Date of Birth:*_____

*Signature of Patient or Personal Representative:*_____ *Date*_____

*Print Name of Personal Representative, if applicable:*_____

*Personal Representative's Authority to Act:*_____
(e.g. parent, guardian, power of attorney, stating relationship to the individual making the request)

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____Communications barriers prohibited obtaining the acknowledgment

_____An emergency situation prevented us from obtaining acknowledgment

_____Other (please specify)

_____

_____

PALADIN DENTAL

2747 W. Bullard Avenue, Suite 103

Fresno, CA 93711

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/1/17.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment. We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Options. We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization. In addition to our use of your health information for treatment and payment of healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care. We may use or disclose health information to notify, or assist in the notification of (including identifying of locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

National Security. We may disclose military authorities the health information on Armed Forces personnel under certain circumstances. WE may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders. We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0__for each page, $__per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclose of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of his Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Nasir Sadeghi

Telephone: (559) 436-8288 Fax: (559) 436-0400

Email: paladindental@gmail.com

Address: 2747 W. Bullard Avenue, Suite 103, Fresno, CA 93711

PATIENT CONSENT TO TREATMENT

PATIENT'S NAME _____ BIRTHDAY_____

1. DRUGS, MEDICATIONS, AND ANESTHESIA

INITIAL_____

* I understand that antibiotics, analgesics and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, painful itching, vomiting, dizziness, miscarriage, and cardiac arrest.

*I understand that medications, drugs and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from the effects (this includes a period of at least 24 hours after my release from surgery.)

*I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia, numbness and/or irritation to the area of injection.

* I understand that if I select to utilize Nitrous Oxide, "Atarax", Chloral Hydrate, "Zanax" or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock and other cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 8 to 10 hours following my appointment to check for possible deleterious side effects, such as the obstruction of an airway.

2. HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS)

INITIAL_____

*I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintain regular recall visits.

*PERIODONTICS- I understand that I have a serious condition, causing gum and bone inflammation and/or loss and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gun surgery, replacement and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction.

3. REMOVAL OF TEETH

INITIAL_____

*I understand that the purpose of the procedure/surgery is to treat and possible correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time.

*POTENTIAL RISKS INCLUDE, BUT ARE NOT LIMITED TO THE FOLLOWING: post-operative discomfort, swelling, prolonged bleeding, tooth sensitivity to hot or cold, gum shrinkage (possible exposing crown margins), tooth looseness, delayed healing (dry sockets) and/or infection (requiring prescriptions or additional treatment, i.e. surgery);

Injury to adjacent teeth, caps or fillings (requiring the recementation of crowns, replacement of fillings, fabrication of crowns or extraction), or injury to other tissues not within the described surgical area, limitation of opening, stiffness of facial and/or neck muscles, change in bite or temporomandibular joint (jaw point) difficulty (possibly requiring physical therapy or surgery); residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications; possible bone fracture which may require wiring or surgical treatment; opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery; injury to the nerve underlying the teeth resulting in itching, numbness or burning of the lip, chin, gums, cheek, teeth and/or tongue on the operated side, this may persist for several weeks, months or in remote instances, permanently.

I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me or other procedures deemed necessary or advisable as necessary to complete the planned operation.

If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he deems advisable, including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility.

4. FILLINGS

INITIAL_____

*I have been advised of the need for fillings, either or composite (plastic) to replace tooth structure lost to decay. I understand that with times fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build up and crowns) which would necessitate a separate charge.

*I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines, and as such is a treatment used by Paladin Dental. The advantages and disadvantages of alternate materials have been explained to me.

5. ENDODONTIC TREATMENT (ROOT CANAL THERAPY)

INITIAL_____

*The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments, and the consequences of noon-treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a crown (cap) over the tooth.

*I UNDERSTAND THAT TREATMENT RISKS CAN INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING:

Post treatment discomfort lasting a few hours to several days for which medications will be prescribed if deemed necessary by the doctor, Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer, infection, restricted jaw opening, breakage of root canal instrument, which may in the judgment of the doctor, be left in the treated root canal bone as part of the filling material; or it may require surgery for removal, perforation of the root canal with instruments, which may require additional treatment or result in premature tooth loss or extraction, risk of temporary or permanent numbness in treatment area.

If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment and I need to pay for, and finish final root canal therapy. If root canal treatment is not finalized, I expose myself to infection and/or tooth loss.

If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted.

6. CROWN AND BRIDGE **INITIAL**_____

*I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that a times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy.

*I understand that like natural teeth, crowns, and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment.

7. DENTURES—COMPLETE OR PARTIAL **INITIAL**_____

*The problems of wearing dentures have been explained to me including looseness, soreness and possible breakage, and relining due to tissue change. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor.

*I further understand that surgical intervention (i.e. tori (bone) removal, bone recontouring or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction.

8. PEDODONTICS (CHILD DENTISTRY) **INTIAL**_____

*I understand that the following procedures are routinely used at Paladin Dental, as well as being accepted procedures in the dental profession.

*POSITIVE REINFORCEMENT— Rewarding the child who portrays desirable behavior, by use of compliments, praise, a pat or hug, and/or token objects or toys.

*VOICE CONTROL— The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.

*PHYSICAL RESTRAINT—Restraining the child's disruptive movements by holding down their hands, upper body, head and/or legs by use of the dentist's or assistant's hand or arm.

*NITROUS OXIDE AND/OR ORAL SEDATION—Nitrous Oxide is a mild gas that is mixed with oxygen and is used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use, the parent or guardian must understand that the child should NOT eat or drink for a period of four hours prior to the sedation appointment. The parent/guardian must be available to escort the child home after sedation procedure and observe their behavior throughout the day.

I understand that with the use of an injection, used to numb the tooth for dental procedures, the possibility exists that the child may inadvertently bit their lip, causing injury to occur.

I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time.

I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation, and the possibility of it then needing extraction.

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATION OF THE DOCTOR WHILE I AM UNDER HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD THE OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

Signature of Patient/Legal Representative_____ **Relationship**_____ **Date**_____

Doctor_____ **Witness**_____ **Date**_____