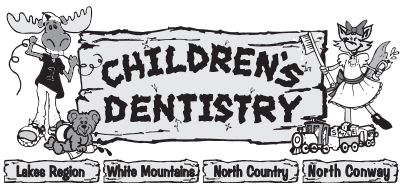

PATIENT TREATMENT AND CONSENT

I hereby authorize and direct Children's Dentistry, and/or any of its dental associates and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (X-Rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan. I understand certain parts of the treatment may be performed by certified paraprofessionals (Dental assistants) other than the Dentist I authorize Children's Dentistry, and/or any of its dental associates and/or dental auxiliaries to take and to use photographs, radiographs, other diagnostic materials, and treatment records for the purposes of teaching, research, and scientific publication. The photographs shall be used for dental records and if in the judgment of Children's Dentistry and/or any of its dental associates, dental research, education, or science republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which she/he may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use my name or my child's name not be identified by name. The aforementioned photographs may be modified or retouched in any way that my Dentist, in his/her discretion, may consider desirable. I understand X-Rays, photographs, models of the mouth, and/or any other diagnostic aid used for an accurate diagnosis and treatment planning are the property of the doctor, but copies are available upon request for a fee. In general terms, the dental procedure(s) can include but not limited to: A. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride or varnish fluoride. B. Application of plastic "sealants" to the grooves of teeth. C. Treatment of diseased or injured teeth with dental restorations (fillings), stainless steel or composite crowns, and/or root canal treatment. D. Oral surgery: Extraction of one or more teeth, excision of hyper plastic and/or pericoronal tissue, frenectomy, exposure of unerupted tooth. E. Placement of space maintainers and/or replacement of missing teeth with dental prosthesis. F. Treatment of diseased or injured oral tissues secondary to traumatic injuries and/or accidents and/or infection. G. Treatment of habits, malposed (crooked) teeth, orthodontia and/or oral, dental developmental or growth abnormalities. H. Recommendation for treatment to be completed using conscious sedation or general anesthesia. I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not possible in dental health service. I have answered all the questions about my or my dependents medical history and present health conditions fully and truthfully. I have told the Dentist or other personnel about all conditions, including allergies, which might indicate that my child should not receive oral medications and/or anti-anxiety agents. I also understand if I or my dependent ever had any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment. I authorize Children's Dentistry and/or any of its dental associates to forward a review of findings and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care giver for his/her records, as well as any third parties such as insurance companies who may request information. 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. I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this consent. I further understand that this consent shall remain in effect until terminated by me or Children's Dentistry. Additional documents upon request at the front desk: Patient Management Techniques, Patient Responsibilities, HIPAA Notice of Privacy Practices and Authorization By signing below you hereby acknowledge that you have read and understand the above mentioned documents and consent for treatment. As a courtesy, we accept assignment of benefits from your insurance carrier. I authorize the release of any information relating to the claim(s). I hereby authorize direct payment to the group insurance benefits otherwise payable to me. I understand the copay and/or deductible is due at the time of treatment. I understand I am responsible for services not covered by insurance. The parent who accompanies the child to our office is responsible for payment at the time of service. It is important that you keep our office aware of changes in your address, phone numbers, and insurance status. Balances on accounts are due 30 days from the process date on the statement. For those patients without insurance coverage, payment in full is required at the time of the treatment.

By signing below you have read and understand our office policies.

_____
Patients Name

_____ _____ _____
Signature of parent/guardian | Relationship to patient | Date