PATIENT CONSENT- ADULT

Clinical

I authorize ***Shallowford Family Dental Group*** to perform all recommended treatment, including but not limited to:

a. All recommended treatment;
b. Radiographs, study models, photos, and other diagnostic aids or materials (collectively, ("Diagnostic Material") as needed to make a thorough diagnosis;
c. The use of anesthetics, sedatives, and other medications, as needed, and am fully aware that using anesthetics agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

HIPAA Acknowledgment

I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, specialty dentists **involved in my care**, any and all information, records, and other diagnostic material about my medical history, services rendered, or recommended treatment.

I acknowledge receipt of the Notice of Privacy Practices.

I authorize sharing my protected health information with the following individuals who may be involved in my care and I understand I am responsible to notify the Practice of any changes:

Name (Please Print) _____ Relationship: _____

Name (Please Print) _____ Relationship: _____

Name (Please Print) _____ Relationship: _____

Printed Name of Patient/Legal Guardian: _____

Signature **of Patient/Legal Guardian:** _____ **Date:** _____

PATIENT CONSENT-MINOR CHILD
(Effective until age 18- Tennessee)

The parent or legal guardian must complete this form for a minor, provide consent for dental treatment, and accompany the child during each dental visit. Treatment will not be provided for unattended minors unless it is an emergency. If you wish to designate another adult to be a decision-maker in your child's dental care, please complete the Limited Power of Attorney. If you authorize sharing protected health information, complete the HIPPA Acknowledgement section below. **Your Child(ren)'s Names:**

Patient's/Child's Name (Please Print): _____ Date of Birth: ____/____/____

Patient's/Child's Name (Please Print): _____ Date of Birth: ____/____/____

Patient's/Child's Name (Please Print): _____ Date of Birth: ____/____/____

Clinical

As the parent/legal guardian of the child(ren) listed above, I authorize ***Shallowford Family Dental Group*** to perform all recommended treatment on the patient, including but not limited to:

a. All recommended treatment;
b. Radiographs, study models, photos, and other diagnostic aids or materials (collectively, ("Diagnostic Material") as needed to make a thorough diagnosis;
c. The use of anesthetics, sedatives, and other medications, as needed, and am fully aware that using anesthetics agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

HIPAA Acknowledgment

I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, specialty dentists involved in my child's care, any and all information, records, and other diagnostic material about my child's medical history, services rendered, or recommended treatment.

I acknowledge receipt of the Notice of Privacy Practices.

I authorize sharing my child's protected health information with the following individuals who may be involved in my child's care and I understand I am responsible to notify the Practice of any changes:

Name (Please Print): _____ Relationship: _____

Name (Please Print): _____ Relationship: _____

Name (Please Print): _____ Relationship: _____

Printed Name of Parent/Legal Guardian: _____

Signature **of Parent/Legal Guardian:** _____ **Date:** _____