PATRICK BRIESE
DENTISTRY
GENERAL DENTISTRY IMPLANT DENTISTRY

Patient Consent Forms

I understand that, under the ***Health Insurance Portability &Accountability Act of 1996 (HIPAA*)**, I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain Payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications**.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to the extent that you have taken action relying on this consent.

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand. We are ready to answer any of your questions or explain anything you need. Any alternatives to the recommended treatment, including no treatment, have been explained to me. In general terms then contemplated dental treatment is:

Hygiene : **prophy, exams, x-rays, full mouth debridement, scaling and root planning**

Operative: **crown, onlay, inlay, bridge preps, occlusal adjustments, splint adjustments, fillings**

I understand dentistry is not an exact science and complications may occur despite a dentist's best efforts. There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or per-medication prior to dental care being rendered.

Some of the risks/complications are, but not limited to, the following:

Sensitivity to temperature , Damage to or loss of filling or other dental work, Incomplete removal of tooth, Damage, fracture or possible loss of tooth being treated, Change in bite as well as adjacent teeth and bone, Failure of wound to heal, Loss of tooth/teeth or bone, Injuries to adjacent teeth and/or soft tissue, Dry socket, Paresthesia (numbness) of tongue, mouth, and/or face, Injury to adjacent structures, Fracture of maxilla (upper jaw) or mandible (lower jaw), Instrument breakage, Opening between mouth and sinus or mouth and nose, Allergic reaction to drugs or anesthetics, Sloughing (unanticipated loss of hard and/or soft tissue), Bacterial Endocarditis (heart infection), Swallowing and/or aspiration of prosthesis or other object, Failure of treatment to accomplish its purpose, Trismus – jaw pain or difficulty opening, TMJ dysfunction or worsening of TMJ condition, Additional surgery, hospitalization, and/or further Injury from airborne particles or instruments treatment may be required, Infection, Breakage of root(s) and retained root fragments, Burns from chemical agents used in treatment, Bleeding, Loss of or damage to the ability to taste, speak, &/or see, Tooth or fragment in maxillary sinus.

State law also requires that I specifically advise you, although rarely occurring, that dental treatment or anesthetic use may result in: Paraplegia
(paralysis of both legs) ; Quadraplegia (paralysis of both arms and legs); loss of function of organ(s) or limb(s); brain damage; death.

ACKNOWLEDGEMENT

I acknowledge that I have read, or that it has been read to me, and I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions that were asked, were answered to my satisfaction. I hereby authorize and direct the dentist and/or associates , hygienists, assistants of their choice to perform the diagnostic, surgical, or dental treatment. This consent form will remain valid until revoked by me in writing.

Signature of Patient or Guardian (if minor)	**Date**