

***Welcome to our office!***

***To assist us in serving you, please complete the following confidential forms, we assure you that all the information we are requesting in this packet is vital to your dental health and to assist in utilizing your dental benefits and minimize your out of pocket costs. Should you need assistance with any of these forms feel free to ask!***

**PATIENT INFORMATION:**

**LAST NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FIRST NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MIDDLE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE \_\_\_\_\_\_\_\_\_ SEX \_\_\_\_\_\_\_\_\_\_\_ SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOME PHONE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MOBILE PHONE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMAIL** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**MAY WE EMAIL YOU?** YES / NO **MAY WE TEXT YOU?** YES / NO

***Is there anything you would like to change about your smile?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOME ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BILLING ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREFERRED PHARMACY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***IF PATIENT IS A MINOR CHILD:***

FULL TIME STUDENT? YES / NO SCHOOL ATTENDING \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRADE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONCERNS TO BE ADDRESSED (IF ANY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPONSIBLE PARTY:**

**LAST NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FIRST NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MIDDLE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE \_\_\_\_\_\_\_\_\_ SEX \_\_\_\_\_\_\_\_\_\_\_ SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATION TO PATIENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMPLOYER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOME ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BILLING ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT MEDICAL HISTORY:**

|  |  |
| --- | --- |
| Do you have or have you had any of the following? (Please check any that apply)* Cancer or tumor
* Heart ailment or angina
* Heart murmur, mitral valve prolapse, heart defect
* Rheumatic fever or rheumatic heart disease
* Artificial joint or valve
* High or low blood pressure
* Pacemaker
* Tuberculosis or other lung problems
* Kidney disease
* Hepatitis or other liver disease
* Alcoholism
* Blood transfusion
* Diabetes
* Neurologic condition
* Epilepsy, seizures, or fainting spells
* Emotional condition
* Arthritis
* Herpes or cold sores
* AIDS or HIV positive
* Migraine headaches or frequent headaches
* Anemia or blood disorders
* Abnormal bleeding after extractions, surgery, or trauma
* Hayfever or sinus trouble
* Allergies or hives
* Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ noDo you pre-medicate before any dental procedures? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Are you allergic to, or have you reacted adversely to any of the following?* Latex materials
* Penicillin or other antibiotics
* Local anesthetics ("Novocain")
* Codeine or other narcotics
* Sulfa drugs
* Barbiturates, sedatives, or sleeping pills
* Aspirin
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any of the following?* Aspirin
* Anticoagulants (blood thinners)
* Antibiotics or sulfa drugs
* High blood pressure medicine
* Antidepressants or tranquilizers
* Insulin, Orinase, or other diabetes drug
* Nitroglycerin
* Cortisone or other steroids
* Osteoporosis (bone density) medicine
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Women:* May be pregnant

 Expected delivery date: \_\_\_\_\_\_\_\_\_\_\_\_\_* Taking hormones or contraceptives

**PHYSICIAN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TEL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Do you have any disease, condition, or problem not listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**INSURANCE INFORMATION:**

|  |  |  |
| --- | --- | --- |
| **INSURANCE COMPANY: PRIMARY□ SECONDARY□** | **TELEPHONE NUMBER:** |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **SUBSCRIBER NAME:** |  |  |  |  | **SUBSCRIBER DOB:** |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **SUBSCRIBER EMPLOYER:** |  |  |  | **GROUP NUMBER:** |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **SUBSCRIBER ID:** |  |  |  |  | **RELATION TO PATIENT:** |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **INSURANCE COMPANY: PRIMARY□ SECONDARY□** | **TELEPHONE NUMBER:** |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **SUBSCRIBER NAME:** |  |  |  |  | **SUBSCRIBER DOB:** |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **SUBSCRIBER EMPLOYER:** |  |  |  | **GROUP NUMBER:** |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **SUBSCRIBER ID:** |  |  |  |  | **RELATION TO PATIENT:** |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

**Statement of True and Accurate Information**

*The information I have provided is true and correct to the best of my knowledge/belief. I authorize any provider of services to furnish any information requested. I also hereby authorize my dental plan administrator to release or obtain from my organization or person information that may be necessary to determine benefits payable under the group benefits with the dental benefit plan. A Photo copy of this authorization shall be considered as effective and valid as the original.*

*Although I have requested that the dentist bill my dental insurance on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in full within 45 days. If for any reason my dental insurance company does not pay any portion of my bill, I further agree to make prompt payment of the balance/bill.*

*I understand that I am responsible for all of the charges for all services rendered to myself or any member of my family. I understand an assessment of $50 will be charged to my account if I fail to cancel any appointment without at least 48-hour notice.*

*I hereby authorize payment directly to the provider of the dental benefits otherwise payable to me:*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature (parent/guardian if minor child) Date**

**Acknowledgment of Receipt of Notice of Privacy Practices**

I, (print name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read a copy (displayed in waiting area, and/or given a copy upon request) of this office’s notice of Privacy Practices. If you would like a hard copy for your records, please let us know and we can provide one for you.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature (parent/guardian if minor child) Date**

**Consent for Social Media and Electronic Communication**

I, (print name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent North Haven Family Dentistry to use photographs or videos of myself and/or my family members on their social media tools (Instagram, Facebook, Yelp,YouTube,SnapChat etc.). I also consent North Haven Family Dentistry to send me links for office reviews via text and/or email. I understand that my information, images and/or videos will not be used for any other commercial purposes.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature (parent/guardian if minor child) Date**

Family members to be included in consent:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For office Use Only:**

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained due to:

\_\_\_Individual refused to sign

\_\_\_ Communication barrier prohibited obtaining acknowledgement

\_\_\_ An emergency situation prevented us from obtaining acknowledgement

\_\_\_ other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Agreement**

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE.

If a procedure requires multiple appointments, payment is required in full at the first appointment.

**Payment options:**

* Cash
* Check
* MasterCard
* Visa
* Novus/Discover
* Credit card authorization for recurring charges:

a. Treatment exceeds $200

b. Plan may not exceed 4 months

**Patient with insurance:** The PATIENT is responsible for the ***ESTIMATED*** non-covered portion, procedures and/or deductibles at the time of the service, OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

**Parents not accompanying their child** to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).

**Parents accompanying their children** are financially responsible for payment.

18% annual **interest** is charged for any unpaid balance. A $15 fee is charged for nonpayment.

There is a $30.00 processing charge for **non-sufficient funds** or returned checks.

**Records** can be viewed at any time. There is a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **$25 - $50 CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE**.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , agree to the financial terms for North Haven Family Dentistry and have had the opportunity to ask any questions regarding the financial policy.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Initial Exam, X-Rays & Cleaning Informed Consent**

**Paitent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Examinations & X-rays:** I understand that the initial visit will require radiographs in order to complete the examination, diagnosis and treatment plan. I understand that Dr Prameela Bhupatiraju will perform an examination, resulting in her diagnosis and a treatment plan. It is Dr Prameela Bhupatiraju’s standard of care to perform two examinations and two sets of dental x-rays twice a year, typically every 6 months *regardless of insurance frequencies, limits, and/or payment.* (\_\_\_\_\_\_\_\_)initial
2. **Dental Prphylaxis (Cleaning-healthy mouth):** I understand that this type of cleaning is preventative in nature and intended for patients with healthy gums, and is limited to the removal of plaque and extremely light tartar and stain from the tooth structures in the absence of periodontal (gum) disease. This type of cleaning ***prevents*** gingivitis and gum disease. (\_\_\_\_\_\_\_\_)initial
3. **Debridement (detailed cleaning):** I understand that this type of cleaning is preventative in nature and intended for patients with gingivitis (inflamed and bleeding gums) and is for the removal of heavy build up of tartar and stain from the tooth structures in the absence of periodontal (gum) disease. This type of cleaning ***prevents*** gum disease. (\_\_\_\_\_\_\_\_)initial
4. **Periodontal Treatment (Scaling and root planning, deep cleaning):** I understand that this type of cleaning is for a serious condition causing gum inflammation and/or bone loss, which can lead to the loss of my teeth and/or negative sytstematic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatments include non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/.or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed by Dr Bhupatiraju, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long term success of dental restorative work. (\_\_\_\_\_\_\_\_)initial
5. **Drugs, medications and sedation:** I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or fully recovered from the effects of the anesthetic, medication and drugs that may have been prescribed to me for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking. I have informed Dr Bhupatiraju of any drug allergies. (\_\_\_\_\_\_\_\_)initial
6. **Changes in Treatment Plan(s):** I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination, with the most common being root canal therapy following routine restorative procedures. I give my permission to Dr Bhupatiraju to make changes and additions as necessary. (\_\_\_\_\_\_\_\_)initial
7. **Tempro-mandibular Joint Dysfunction (TMD):** I understand that popping, clicking, locking, and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitionary in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which will remain my responsibility. (\_\_\_\_\_\_\_\_)initial

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature (Parent/Guardian if minor child) Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Parent or Guardian if minor child Relation to Patient, if minor child**

**Minor Consent**

**Minor Child Consent**

**I, being the parent or guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(minor child name(s)), do hereby request and authorize the dental staff to perform necessary dental services for my child, including x-rays, nitrous oxide (laughing gas), administration of anesthesia, and any services deemed advisable by the doctor, even if I am not present in the operatory during the dental treatment. (\_\_\_\_\_\_\_\_)initial**

**Permission to Treat**

**Because your child is a minor it is necessary to have signed permission from a parent or guardian. The signature affixed below authorizes examination and treatment as necessary and the use of procedures the doctor may deem necessary during the performance of dental services. Furthermore the undersigned accepts responsibility of any financial obligations incurred for treatment of this patient. Photos and other dental records of my child may be used for teaching or instructional purposes. (\_\_\_\_\_\_\_)initial**

**Dental Treatment**

**I understand that during the treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the initial examination. I give my permission to the dentist to make any/all changes and additions as necessary. I consent to the use of photography for the purposes of future education and display of specific dental procedures performed by North Haven Family Dentistry and/or Dr Prameela Bhupatiraju. (\_\_\_\_\_\_\_)initial**

**Assignment of Consentors**

**In my absence I consent for the following individuals to sign for treatment for my minor child or children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(minor child name(s)).**

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relation to child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relation to child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relation to child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relation to child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relation to child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature (Parent/Guardian if minor child) Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Parent or Guardian if minor child Relation to Patient, if minor child**