Chamber Family Dentistry

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Consent For Dental Treatment

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at Chamber Family Dentistry. These procedures include, but are not limited to: examinations, oral prophylaxes (cleaning), Fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontics (root canals) treatment, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk of swelling, bruising, and allergic reactions, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

Print Patient name _____ Date _____

Patient or Guardian signature _____ Date _____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office receives this authorization receives a written revocation, although that not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign form.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Print Patient Name _____ Date _____

Patient or Guardian signature _____ Date _____