Acknowledgement Of Receipt
Of
Notice Of Privacy Practices

I, _____ have received a copy of
(Name of Patient)

HELOTES COSMETIC & FAMILY DENTISTRY, PLLC's Notice of Privacy Practices.

_____

(Signature of Patient/Legal Guardian) Date

Staff Will Fill Out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notice of Privacy Practices, but it could not be obtained for the following reason:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient's signature.

_____ Language barriers kept us from obtaining the patient's signature.

_____ Other _____

INFORMED CONSENTS FOR DENTAL TREATMENT

Print Patient's Name **Legal Guardian's Name** **Date**

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

_____1. TREATMENT: I understand I am or my _____ is having the following dental treatment performed:
_ Examination _ X-rays _ Prophy _ Scaling & Root Planning _ Sealants _ Filling
_ Anesthetic Injection _ Root Canals _ Implant _ Extraction _ Crown/Bridge _ Crown Build up
_ Dentures _ Other _____

_____2. DRUGS AND MEDICATIONS: I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. I also understand that certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such medications.

_____3. FILLINGS: I understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement.

_____4. CROWNS & BRIDGES: I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will notify Dr. Hien Nguyen of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final fabrication of the restoration. It is my responsibility to return within three week of tooth preparation for final cementation of the restoration. I understand I may need further treatment by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.

_____5. DENTURES: I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent." Sore spots, altered speech and difficulty eating are common problems. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require frequent adjustment and one or more definitive relines within several months. I understand that failure to keep appointments may result in a less desirable result. If remake is required due to my delay, additional fees may be incurred on my part.

_____6. EXTRACTIONS: Alternatives to tooth removal include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. It is my understanding that the following teeth will be removed:_ _____. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I have been told that the risks of removing teeth include, but are not limited to: pain, swelling, infection, dry socket, fracture of bone or jaw, and loss of feeling in my lip and or other facial areas, cheek, tongue, gums and teeth. Such numbness may be temporary or permanent. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

_____7. PERIODONTAL DISEASE: Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends significantly on my

continuing home care and faithful adherence to Dr. Hien Nguyen's instruction, including strict observance of recall appointments. I understand that care by a specialist may be necessary, at additional cost to me.

_____**8. ROOT CANAL: I realize there is no guarantee that root canal treatment will save a tooth, and complications can occur during and after treatment. Occasionally the canal filling material may extend through the end of the root, which may or may not affect the success of treatment, and which may require additional treatment. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not affect success. I understand that occasionally additional surgical procedures (apicoectomy) may be necessary to complete therapy. I also understand that an undetectable hairline crack in a tooth may cause failure, no matter how extensive therapy may be. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise, at my own cost.**

_____**9. SEALANT: Sealant is a thin coat of resin material applied to seal out the deep grooves and pits of newly erupted teeth, in the effort to prevent decays from occurring in those areas.**

_____**10. TREATMENT PLAN MODIFICATIONS: I understand that during treatment it may be necessary to change the planned procedures because of conditions discovered during treatment that were not evident during examination. I authorize Dr. Hien Nguyen to use professional judgement to provide appropriate care, or, if it deems necessary, to refer me to appropriate Specialist for continue treatment of my dental condition.**

_____**11. ALTERNATIVE TREATMENT: Includes**

_____
_____
_____
_____

_____ **I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made, either orally or written, regarding the dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that if I need to see a Specialist to treat or resolve my dental problem, I will solely be responsible for all charges incurred.**

CONSENT: I have truthfully revealed all aspects of my health history. I agree to cooperate fully with the recommendations of Dr. Hien Nguyen, realizing that lacks of cooperation may result in a less-than-optimum result. Furthermore, I have had the opportunity to have all my questions answered by Dr. Hien Nguyen or his qualified staff member, and I certify that I understand English and/or having a translator to assist me to fully understand my treatment options. My signature below signifies that I fully understand the benefits, risks of the treatment options, including no treatment, that are proposed to me. I hereby give my consent for the treatment I have chosen, and for releasing my information to my insurance carriers for reimbursement of my dental service, directly to Helotes Cosmetic & Family Dentistry. I agree to pay for any applicable financial liability, as services are rendered, unless prior financial arrangement has been made. I understand that I am ultimately responsible for all balances on my account, including charges not covered by my insurance, within 30 days from receiving notice from Helotes Cosmetic & Family Dentistry. In addition, I will solely be responsible for any/all legal and collection fees, if my account with Helotes Cosmetic & Family Dentistry or Dr. Hien T. Nguyen should become delinquent. I understand that, as a patient, I need to keep and be on time to all of my scheduled appointments. A Twenty five ($25.00) dollars charge will be imposed into my account for each no show, unless such no show was a result of an accident or a medical emergency, or when I fail to notify the office about my cancellation, within 24 hours in advance of my appointment day.

_____

Patient's (or Legal Guardian's) Signature **Date**

_____

Doctor's Signature **Date**

_____

Witness'/ Translator's Signature **Print Name Here** **Date**