ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print name) ____
have received a copy of this office's Notice of Privacy Practices.

____
Signature

____
Date

PLEASE ASK FOR A COPY IF NEEDED****

For Office Use Only
We attempted to obtain written acknowledgment of receipt of Notice of Privacy Practices, but acknowledgment could not be obtained because:

___ Individual refused to sign
___ Communications barriers prohibited obtaining the acknowledgment
___ An emergency situation prevented us from obtaining acknowledgment
___ Other (Please specify)

AUTHORIZATION FOR DENTAL TREATMENT

I hereby authorize Smyrna Dental Center and his/her associates to provide dental services, prescribe, dispense and/or administer any drugs, medicaments, antibiotics and local anesthetics that he/she or his/her associates deem, in their professional judgment, necessary or appropriate in my care.

I am informed and fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment and extractions (tooth removal).

The most common risks can include, but not limited to:
Bleeding, swelling, bruising, stiff jaws, infection, aspiration, parasthesia, nerve disturbance
or damage either temporary or permanent, adverse drug response, allergic reaction, cardiac arrest.

I understand that it is mandatory to follow any instructions given by the dentist and/or his/her associates and take medications as directed.

Alternative treatment options, including no treatment have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Date: ______________________________________

Patient Name: ______________________________________

Legal Guardian/
Patient Signature: ______________________________________