# CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of _____ and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

    A. Preventive hygiene treatment, (prophylaxis) and the application of topical fluoride.
    B. Application of plastic "sealants" to the grooves of the teeth.
    C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
    D. Replacement of missing teeth with dental prostheses, (bridges, partial dentures, full dentures).
    E. Removal (extraction) of one or more teeth.
    F Treatment of diseased or injured oral tissues (hard and/or soft).
    G. Use of sedative drugs to control apprehension and/or disruptive behavior.
    H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
    I. Use of general anesthesia to accomplish the necessary treatment.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will he explained to me, that I will have an opportunity to ask questions regarding the treatment and d1e risks, and that I fully understand the same.

3. I will be advised that d1e success of the dental treatment to be provided will require d1at the patient and/or parents of the patient follow post-operative and post-care instructions of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore aud1orize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being, in the professional judgement of the dentist.

5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fain ting, lip or cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgement of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

7. I also authorize the doctors to use photographs, radiographs, other diagnostic materials: and treatment records for the purposes of teaching, research and scientific publications.

8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: _____ Time: _____ AM / PM File No: _____

Patient's Name: _____

Name of Parent or Guardian: _____

Relationship to Patient: _____

_____ _____

Signature: Patient or Parent or Guardian Witness

Janelle B. Bicknell, D.D.S
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# HIPAA Disclosure

I understand that, under the Health Insurance Portability & Accountability Act of 1996, as amended and supplemented (HIPAA). I have certain rights to privacy regarding my protected health information {PHI). PHI may originate in your medical record at Dr. Janelle Bicknell's office or may be received from outside health entities and filed in your medical record.

I understand that this information can and will be used by our office to:(a) conduct. plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly, (b) Obtain payment from third-party payers, (c) Conduct normal healthcare operations such as quality assessments and physician certifications, (d) Notification of educational events specific to my medical condition through our office or networking organizations, (e) Consent to properly transfer of specimen (tissue obtained during a medical test) to our office and (n Any such other purposes permitted under HIPAA.

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 understand that Dr. Janelle Bick ell's office has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from my local office or by contacting the Privacy Officer at 6333 Nth. State Highway 161, Suite 200, Irving, TX 75038.

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 any time, except to the extent that you have taken action relying on this consent.

## Designation of Those Who Can Receive Information About My Care

To allow a family member, other relative, or a close personal friend to have access to PHI.
I designate the following individuals to have access to information about me that is created by or on behalf of our office and that this information can include PHI. I understand that I may revoke this designation at any time by completing a new form; and that this designation will not expire unless and until! actively revoke.it. I understand that these individuals will not be able to request a paper or electronic copy of my health records without my having completed an Authorization to Release Medical information form.

I understand that my healthcare treatment or payment, or my enrollment or eligibility for benefits cannot be conditioned on my designating or not an individual below.

I understand that this designation does NOT allow for the release of. any information concerning drug abuse, alcohol abuse, psychological or psychiatric conditions, HIV/AIDS testing or status, abortion, or sexually transmitted disease, if any.

Name _____ Relationship _____ Phone#: _____

Name _____ Relationship _____ Phone#: _____

### I prefer to be contacted in the following manner:

Primary Phone#: _____

- ☐ Leave message with contact number only.
- ☐ Leave message with detailed information.
- ☐ Do not leave message.

Secondary Phone#: _____

- ☐ Leave message with contact number only.
- ☐ Leave message with detailed information.
- ☐ Do not leave me sage

### I prefer to receive reminders regarding upcoming appointments in the following manner:

☐ Leave message. ☐ Text

_____ _____ _____
Signature of Patient or Personal Representative | Patient Date of Birth | Date