## DR. MICHAEL LOESER D.M.D.

Account #	Date		
PERSONAL			
Patient's Name	(Male) / (Fer	nale) PHONE NUMBER:	
Birth date		al Security Number	
	THE ACCOUNT(complete name)		
Relationship to patient		Date of Birth	1
Home Address	City	Zip Cod	e
Employer	Phone number	r	
Spouses name	Dat	e of Birth	
Spouse's Employer		Phone Number	
Name of nearest adult relative n	not living with you		
Address	-	Phone	
Whom may we thank for referri	ng you?		
(INSURANCE)			
PRIMARY INSURANCE PLAN			
Address		of Insured	
Date of Birth	Social Security Number	or mourou	
Name of Employer	Address of	Fmnlover	
Employer phone number	Insurance Group or		
Policy or Membership number	Effective		
SECONDARY INSURANCE PL		duto	
Address		of Insured	
Date of Birth	Social Security Number	or moured_	
Name of Employer	Address of	Fmplover	
Employee phone number	Insurance Group or		
Policy or Membership number	Effective		
	ENT-(1.5% Interest will be charged pe		days past dual
	ointment, ( If we are billing your insu		
	r credit cards.) I authorize release of an		
	rance payments to be made directly to		
	ree to pay all attorney fees, court costs,	and a collection charge of 40%,	which will be added
to the outstanding balance of m		or.	
DATE: /PATI	<u>ENT OR LEGAL GUARDIAN SIGNATUI</u>	1C: *************************	***********
DI FASE ANSWED THE FOLLO	WING QUESTIONS AS COMPLETELY	AS DOSSIDI E. (Cirolo ana)	
	WING QUESTIONS AS COMPLETELY		No
			No No
	alth?		No
	r the care of a physician?		No
	edicine? If so for what?		No
	pregnant?		No
	heart or blood trouble?		No
	hepatitis?		No
	uise easily? Penicillin or any drugs and local anesthe		IVO
			No
	o fainting? en Phen-Phen or any other diet pills?		No
	d a severe reaction to a dental treatment		No
13. When did you see		I 1es	140
14. Name of Medical		Phone number	
			had.
	following conditions		
HEART DISEASE	STROKE DIABETES	TUBERCULOSIS	ULCER
HEART MURMUR	ASTHMA EPILEPSY	LIVER DISEASE	HEPATITIS
ARTHRITIS	RHEUMATISM JAUNDICE	RHEUMATIC FEVER	BLOOD DISORDER
SINUS TROUBLE	THYROID TROUBLE	HIGH BLOOD PRESSURE	KIDNEY DISEASE
VENEREAL DISEASE			
ANY OTHER CONSTITUTIONAL			

# DR. CURTIS CONDIE D.D.S.

Account #	Date		
PERSONAL			
Pationt's Name	(Malo) / (Fem	ale) PHONE NUMBER:	
Birth date	Age Patients Social	Security Number	
PERSON RESPONSIBLE FOR THE	ACCOUNT(complete name)		
Relationship to patient	Social Security Number	Date of Birth	
Home Address	City	Zip Gode	)
Employer	Phone number		
Spouses name	Date	of Birth	
Spouse's Employer	living with you	Phone Number	
Name of nearest adult relative not	living with you	Division	
Address		Phone	
Whom may we thank for referring	you?		
(INSURANCE)			
PRIMARY INSURANCE PLAN			
Address		of Insured	
Date of Birth	Social Security Number		
Name of Employer	Address of	Employer	
Employer phone number	Insurance Group or F	lan number	
Policy or Membership number	Effective	date	
SECONDARY INSURANCE PLAN			
Address		of Insured	
Date of Birth	Social Security Number	r I	
Name of Employer	Address of	Employer	
Employee phone number	Insurance Group or	Plan number	
Policy or Membership number	Enective	gate	
FINANCIAL AGREEME	NT-(1.5% Interest will be charged per	month for any amount over bu	days past due)
Payment due on appoi	ntment, ( If we are billing your insu	rance company we will gladly	Estimate" your
notion We pagent most major of	redit cards \ \ authorize release of any	information relating to this cla	im to my insurance
componing Lalen authoriza incurs	ance navments to be made directly to r	ny dentist. If the account is as	signed to all outside
agency for collection, I / we agree	e to pay all attorney fees, court costs, a	and a collection charge of 40%,	which will be added
to the outstanding balance of my	account.		
DATE: /PATIE	NT OR LEGAL GUARDIAN SIGNATUR	{ <b>!</b> :	******
PLEASE ANSWER THE FOLLOW	ING QUESTIONS AS COMPLETELY	Voc	No
1. Are you in pain?		Voc	No
2. Are you in good heal	th?	Vac	No
3. Are you now under t	he care of a physician?	Yes	No
4. Do you take any med	dicine? If so for what?		No
5. WUMEN: Are you pr	regnant?	Yes	No
6. Have you ever had h	eart or blood trouble?	Yes	No
7. Have you ever had h	epatitis?	Yes	No
8. Do you bleed or brui	se easily?	***************************************	
9. Are you allergic to P	enicillin or any drugs and local anesthe	Yes	No
10. Are you subject to	fainting?		No
11. Have you ever take	n Phen-Phen or any other diet pills?	?Yes	No
	a severe reaction to a dental treatment	MATERIAL MATERIAL STATE OF THE	***
	your dentist last?	Phone number	
14. Name of Medical D	octor	which you have	had:
Circle any of the	following conditions	TUBERCULOSIS	ULCER ULCER
HEART DISEASE	STROKE DIABETES	LIVER DISEASE	HEPATITIS
HEART MURMUR	ASTHMA EPILEPSY	RHEUMATIC FEVER	BLOOD DISORDER
ARTHRITIS	RHEUMATISM JAUNDICE	HIGH BLOOD PRESSURE	KIDNEY DISEASE
SINUS TROUBLE	THYROID TROUBLE	HIGH BLOOD FILESSORE	(doith block to
VENEREAL DISEASE	DICORDEDCS (Planes and A)		
ANY OTHER CONSTITUTIONAL I	DISOUDERS: (Lieaze shecily)		

## DR. NICK J. RUDELICH D.D.S.

PERSONAL			
			** * *
Patient's Name	(Male) / (Fem	ale) PHONE NUMBER:	
Birth date		Security Number	
	R THE ACCOUNT(complete name)		
Relationship to patient	Social Security Number	Date of Birth	
Home Address	City	Zip Cod	e
Employer	Phone number		<del></del>
Śpouses name `	Date	e of Birth	
Spouse's Employer		Phone Number	<del></del>
	e not living with you		
Address		Phone	<del></del>
Whom may we thank for refe	erring you?		<del></del>
(INSURANCE)			
PRIMARY INSURANCE PLA			
Address		of Insured	
Date of Birth	Social Security Number		
Name of Employer	Address of		
Employer phone number	Insurance Group or F		
Policy or Membership number		date	
SECONDARY INSURANCE		-f1	
Address		of Insured	
Date of Birth	Social Security Number Address of	Employee	
Name of Employer	Insurance Group or		<del></del>
Employee phone number Policy or Membership number			
			dava poet dual
	MENT-(1.5% Interest will be charged per		
Payment due on ap	pointment, ( If we are billing your insu	rance company we will gladly	Estimate your
portion. We accept most ma	ajor credit cards.) I authorize release of any	/ information relating to this cla	im to my insurance
companies, I also authorize ii	nsurance payments to be made directly to r	ny dentist. If the account is as	signed to an outside
	agree to pay all attorney fees, court costs, a	and a collection charge of 40%,	which will be added
to the outstanding balance of	r my account. <mark>ATIENT OR LEGAL GUARDIAN SIGNATU</mark> F	or.	
DATE: /P/	**************************************	1L. ******************	
PLEASE ANSWER THE FOL	LOWING QUESTIONS AS COMPLETELY	AS POSSIBLE: (Circle one)	******
	?		
		1es	No
Z. Are you in good	health?		No No
	health?der the care of a physician?	Yes	
3. Are you now un	der the care of a physician?	Yes	No
3. Are you now un 4. Do you take any	der the care of a physician? y medicine? If so for what?	Yes Yes	No No
3. Are you now un 4. Do you take any 5. WOMEN: Are yo	der the care of a physician? y medicine? If so for what? ou pregnant?	Yes Yes Yes Yes Yes	No No No
3. Are you now un 4. Do you take any 5. WOMEN: Are you 6. Have you ever h	der the care of a physician? medicine? If so for what? ou pregnant? nad heart or blood trouble?	Yes Yes Yes Yes Yes Yes Yes Yes	No No No No
3. Are you now un 4. Do you take any 5. WOMEN: Are you 6. Have you ever h 7. Have you ever h	der the care of a physician? y medicine? If so for what? ou pregnant?	Yes	No No No No No
3. Are you now un 4. Do you take any 5. WOMEN: Are you 6. Have you ever h 7. Have you ever h 8. Do you bleed or	der the care of a physician? y medicine? If so for what? ou pregnant?ad heart or blood trouble?ad hepatitis?	Yes	No No No No No
3. Are you now un 4. Do you take any 5. WOMEN: Are you 6. Have you ever h 7. Have you ever h 8. Do you bleed or 9. Are you allergic	der the care of a physician? y medicine? If so for what? ou pregnant? nad heart or blood trouble? had hepatitis?	Yes	No No No No No
3. Are you now un 4. Do you take any 5. WOMEN: Are you 6. Have you ever h 7. Have you ever h 8. Do you bleed or 9. Are you allergic 10. Are you subject	der the care of a physician? y medicine? If so for what? ou pregnant? nad heart or blood trouble? and hepatitis? bruise easily? to Penicillin or any drugs and local anesthe	Yes	No No No No No No
3. Are you now un 4. Do you take any 5. WOMEN: Are you 6. Have you ever h 7. Have you ever h 8. Do you bleed or 9. Are you allergic 10. Are you subject 11. Have you ever	der the care of a physician? y medicine? If so for what? ou pregnant? nad heart or blood trouble? bruise easily? to Penicillin or any drugs and local anesthe	Yes	No No No No No No
3. Are you now un 4. Do you take any 5. WOMEN: Are you 6. Have you ever h 7. Have you ever h 8. Do you bleed or 9. Are you allergic 10. Are you subject 11. Have you ever 12. Have you ever 13. When did you	der the care of a physician?	Yes	No No No No No No No
3. Are you now un 4. Do you take any 5. WOMEN: Are you 6. Have you ever h 7. Have you bleed or 9. Are you allergic 10. Are you subject 11. Have you ever 12. Have you ever 13. When did you 14. Name of Medic	der the care of a physician?	Yes	No N
3. Are you now un 4. Do you take any 5. WOMEN: Are you 6. Have you ever h 7. Have you ever h 8. Do you bleed or 9. Are you allergic 10. Are you subject 11. Have you ever 12. Have you ever 13. When did you s 14. Name of Medic	der the care of a physician?	Yes	No N
3. Are you now un 4. Do you take any 5. WOMEN: Are you 6. Have you ever h 7. Have you bleed or 9. Are you allergic 10. Are you subject 11. Have you ever 12. Have you ever 13. When did you 14. Name of Medic	der the care of a physician?	Yes	No N
3. Are you now un 4. Do you take any 5. WOMEN: Are you 6. Have you ever h 7. Have you ever h 8. Do you bleed or 9. Are you allergic 10. Are you subject 11. Have you ever 12. Have you ever 13. When did you s 14. Name of Medic	der the care of a physician?	Yes	No No No No No No No No No UCER HEPATITIS
3. Are you now un 4. Do you take any 5. WOMEN: Are you 6. Have you ever h 7. Have you ever h 8. Do you bleed or 9. Are you allergic 10. Are you subject 11. Have you ever 12. Have you ever 13. When did you and you come to the company of the compan	der the care of a physician?	Yes	No No No No No No No No No UCER HEPATITIS BLOOD DISORDER
3. Are you now un 4. Do you take any 5. WOMEN: Are you 6. Have you ever h 7. Have you ever h 8. Do you bleed or 9. Are you allergic 10. Are you subject 11. Have you ever 12. Have you ever 13. When did you s 14. Name of Medic  Circle any of the HEART DISEASE HEART MURMUR	der the care of a physician?	Yes	No No No No No No No No No UCER HEPATITIS
3. Are you now un 4. Do you take any 5. WOMEN: Are you 6. Have you ever h 7. Have you ever h 8. Do you bleed or 9. Are you allergic 10. Are you subject 11. Have you ever 12. Have you ever 13. When did you s 14. Name of Medic  Circle any of th HEART DISEASE HEART MURMUR ARTHRITIS	der the care of a physician?	Yes	No No No No No No No No No UCER HEPATITIS BLOOD DISORDER

## DR. VICTOR O. PICKETT D.M.D.

PERSONAL	Date		
- F10011/1L			
Patient's Name	(Male) / (F.	emale) PHONE NUMBER:	
Birth date	Age Patients Soc	cial Security Number	
PERSON RESPONSIBLE FOR TH	IE ACCOUNT(complete name)		
Relationship to patient	Social Security Number	Date of Bi	rth
Home Address	City	Zip Co	
Employer	Phone numb		
Spouses name	Da	ate of Birth	
Spouse's Employer		Phone Number	
Name of nearest adult relative not	t living with you		
Address		Phone	
Whom may we thank for referring	J you?		
(INSURANCE)			
PRIMARY INSURANCE PLAN_			
Address	Name	e of Insured	
Date of Birth	Social Security Number		
Name of Employer	Address of	of Employer	
Employer phone number		r Plan number	
Policy or Membership number	Effectiv	ve date	
SECONDARY INSURANCE PLAN		· .	
Address	Name	e of Insured	
Date of Birth	Social Security Number		
	Address of	of Employer	
Employee phone number Policy or Membership number	Insurance Group o	r Plan number	
	Effectiv	e date	
FINANCIAL AGREEME	NT-(1.5% Interest will be charged pe	er month for any amount over 6	0 days past due)
Payment due on appoir	ntment, ( If we are billing your ins	surance company we will gladly	"Estimate" your
portion. We accept most major ci	redit cards.) I authorize release of an	ny information relating to this of	aim to my incurence
companies, i also authorize insura	nce payments to be made directly to	my dentist If the account is a	seigned to an outside
agency for collection, I / we agree	to pay all attorney tees, court costs.	and a collection charge of 40%	, which will be added
to the outstanding balance of my a	account.		
**************************************			
	II UK LEGAL GUARDIAN SIGNATU	IRE:	
PLEASE ANSWER THE FOLLOW	IT UK LEGAL GUAKDIAN SIGNATU	RE:	
PLEASE ANSWER THE FOLLOW	ING QUESTIONS AS COMPLETELY	AS POSSIBLE: (Circle one)	********
1. Are you in pain?	ING QUESTIONS AS COMPLETELY	AS POSSIBLE: (Circle one)	No
Are you in pain?      Are you in good health     Are you now under the	ING QUESTIONS AS COMPLETELY  h?	AS POSSIBLE: (Circle one)YesYes	No No
Are you in pain?      Are you in good health     Are you now under the	ING QUESTIONS AS COMPLETELY  h?	AS POSSIBLE: (Circle one)YesYes	No No No No
1. Are you in pain? 2. Are you in good healt 3. Are you now under th 4. Do you take any medi	h?e care of a physician?icine? If so for what?	AS POSSIBLE: (Circle one)  Yes  Yes  Yes  Yes  Yes	No No No No No No
1. Are you in pain? 2. Are you in good healt 3. Are you now under th 4. Do you take any medi 5. WOMEN: Are you pre	h?e care of a physician?icine? If so for what?	AS POSSIBLE: (Circle one)  Yes  Yes  Yes  Yes  Yes  Yes	No No No No No No
1. Are you in pain? 2. Are you in good healt 3. Are you now under th 4. Do you take any medi 5. WOMEN: Are you pre 6. Have you ever had he	h?e care of a physician?icine? If so for what?egnant?	AS POSSIBLE: (Circle one)  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Y	No No No No No No No No
PLEASE ANSWER THE FOLLOW  1. Are you in pain?  2. Are you in good healt  3. Are you now under th  4. Do you take any medi  5. WOMEN: Are you pre  6. Have you ever had he  7. Have you ever had he	h?ee care of a physician?eignant?egnant?eart or blood trouble?eart or blood tr	AS POSSIBLE: (Circle one)  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Y	No No No No No No No No No
1. Are you in pain? 2. Are you in good health 3. Are you now under th 4. Do you take any medi 5. WOMEN: Are you pre 6. Have you ever had he 7. Have you ever had he 8. Do you bleed or bruise	h?e care of a physician?eicine? If so for what?egnant?eart or blood trouble?eart or blood trouble?eart or blood trouble?eart or blood trouble?ee easily?e	AS POSSIBLE: (Circle one)  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Y	No No No No No No No No
1. Are you in pain? 2. Are you in good health 3. Are you now under th 4. Do you take any medi 5. WOMEN: Are you pre 6. Have you ever had he 7. Have you ever had he 8. Do you bleed or bruise 9. Are you allergic to Pei	h?	AS POSSIBLE: (Circle one)  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Y	No No No No No No No No No
1. Are you in pain? 2. Are you in good health 3. Are you now under th 4. Do you take any medi 5. WOMEN: Are you pre 6. Have you ever had he 7. Have you ever had he 8. Do you bleed or bruiss 9. Are you allergic to Pei 10. Are you subject to fail	h?	AS POSSIBLE: (Circle one)  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Y	No No No No No No No No No No
1. Are you in pain?	h?	AS POSSIBLE: (Circle one)  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Y	No No No No No No No No No No
1. Are you in pain?	h?	AS POSSIBLE: (Circle one)           Yes           Yes	No No No No No No No No No No
1. Are you in pain?	h?	AS POSSIBLE: (Circle one)  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Y	No N
1. Are you in pain?	h?	AS POSSIBLE: (Circle one)  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Y	No N
1. Are you in pain?	h?	Yes	No N
1. Are you in pain?	h?	Yes	No N
1. Are you in pain?	h?	Yes	No Vo UCER HEPATITIS
1. Are you in pain?	h?	AS POSSIBLE: (Circle one)  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Y	No Vo U No
1. Are you in pain?	h?	Yes	No Vo UCER HEPATITIS

#### Permission to contact via cellular telephone

We want to stay in touch with you regarding your account. Since most people only have cell phones, we will need your permission to call your cell phone. Signing this agreement will allow us to do that. Please let us know if you have any questions or would like to discuss this.

In order for us, or for any other person or entity who provides goods or services to you in connection with this agreement, to contact you regarding servicing your account(s). Including all past and current accounts, or to collect any amount you may owe for any past or current account(s), you expressly authorize us to contact you by telephone at any telephone number, including any cellular, mobile, and other wireless telephone numbers that you have or may attain. You acknowledge that such calls could result in charges to you by your telephone carrier. You also expressly authorize us, and any other person or entity that provides goods or services to you in connection with this agreement, to contact you by sending text messages or e-mails to any of your telephone numbers or e-mail accounts. Methods of contact may include the use of pre-recorded/ artificial voice messages and/or the use of an automatic telephone dialing system, as applicable.

You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned your account(s) for servicing or collection.

iy we have read this disclosure i	and agree that I/we may be contacted as describe	u apove.
Signature:		
14	****	
Print vour name here		

### Southwest Dental 5255 S. 4015 W. Suite 180 Kearns, UT 84118

### NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

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 with my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient name:	
Relationship to patient:	
Signature:	
Date:	i

#### OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time serves are rendered.

Patient who carry dental insurance understand that all dental services furnished are charged directly to the patients and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from the insurance companies and will credit any such collections received to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services to be rendered to me, or at my request, to my minor child or ward by the dentist, l'agree to pay the fees charged for the dental services provided, to the dentist or his/her assignee at the time the services are rendered, or within five (5) days of billing if credit shall be extended. I agree to pay the remaining balance plus reasonable attorney fees, court costs and a collection agency commission of 40% of the delinquent balance if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable in information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any or prior mediation/ arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of individuals with whom I authorize the dentist to discuss my dental care.

I certify that I answered all questions accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined therein.

CONSENT TO PROCEED
l authorize Dr and/or such associates or assistants as she/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health of the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.
I understand that the administration of local anesthetic may cause an untoward reaction or side effect which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, an temporary or rarely, permanent numbness. I understand that occasionally needles break and ma require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissu and cause temporary irritation.
I understand that part of dental treatment, including preventive procedures such as cleanings and basi dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful bot during and after the completion treatment. Dental materials and medications may trigger allergic of

After lengthy appointments, Jaw muscles may also be sore or tender. Holding ones mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is possible for the tongue, cheek, or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

sensitivity reactions.

I understand that part of dental treatment, items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonal, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with standard dental preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:	Date:
Signature:	Date:
(Patient, legal guardian or authorized agent of patient)	. :
Witness:	Date: