CONSENT TO PROCEED

I authorize Dr._____and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or 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 effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's 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 also 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.

I understand that as 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, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery of 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 general 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:_____

Signature:_____ Date:_____
(Patient, legal guardian or authorized agent of patient)

Witness:_____ Date:_____

Clair R. Vernon, D.M.D.

AGREEMENT FOR EXTENSION OF CREDIT

In accordance with the 'Federal Truth in Lending Act', please be advised of the following office policies in connection with the extension of credit. By signing this agreement, the responsible party agrees to:

1. Pay in full each time services are rendered, or by previous financial arrangements, we accept cash, check or most major credit cards.
2. Pay 1.75% per month (21% APR) on any unpaid balance over 60 days from the date of service, with a $3.00 minimum charge per month.
3. Authorize a credit bureau report to be obtained if deemed necessary by this office.
4. I grant my permission to you or your assignee to telephone me at my home or at my workplace to discuss matters related to my account.
5. If this account is assigned to an outside agency for collection, I/we agree to pay all attorney fees, with or without suit, court costs, and a collection fee of 40%, which will be added to the outstanding balance of my account.
6. There will be a $25.00 service charge on all return checks.

INSURANCE BENEFITS

I hereby authorize payment directly to the above named dentist of the insurance benefits otherwise payable to me, but not to exceed the charges show above. I understand that I am financially responsible to any charges not covered by this authorization. I hereby accept the foregoing treatment plan and authorize release of any information related to this claim.

FAILED APPOINTMENTS

Our office diligently tries to confirm each appointment **48 hours** before each visit. Failed appointments hurt the patient, a patient who could have used that time and the dentist whose time is wasted. Overhead doesn't stop just because a patient fails to come. Therefore, we reserve the right to charge up to **$100.00 per hour for failed appointments.**

Signature: _____ **Date:** _____

(Parent, legal guardian or authorized agent of patient)

Witness: _____ **Date:** _____

Please sign the other side