Informed Consent/HIPAA Name:_____

I hereby authorize Ladd Dental Group, Inc. and whoever he/she may designate to perform upon me those dental procedures which we have discussed, and I have accepted in the treatment plan. If any unforeseen condition arises in the course of these designated procedures calling, in their judgment, for procedures in addition to or different from those now contemplated, I further request and authorize whatever he/she deems advisable.

I consent to the treatment plan I have accepted after having been advised of alternate plans of treatment available.

I am informed and fully understand that there could be at any time a student, not employed by Ladd Dental Group, Inc., either job shadowing or directly participating in my treatment. I further consent his/her involvement in my care.

I am informed and fully understand that there are certain risks in any dental treatment. These risks include but are not limited to: post-treatment pressure and temperature sensitivity, pain or throbbing, pulpal inflammation, fracturing of new restorations due to early biting pressures, tenderness of abutment teeth, tenderness of tissues under removable dentures, post-operative pain and throbbing, swelling and re-infection, fracturing of files or the crown portion of the tooth during and following root canal therapy, sensitivity of the teeth and gums during and following dental cleanings. Any of these complications may be temporary or permanent.

I further consent to the administration of any drugs that may be deemed necessary in my case, including, but not limited to: local anesthetics, antibiotics, and analgesics. I understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. These risks include, but are not limited to, the following complications: adverse drug response (e.g. irritation and swelling of a vein), aspiration, pain, discoloration, and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

A more complete explanation of all complications is available to me from the Doctor upon my request.

I am aware that, in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

Date: _____Patient/Guardian: _____Doctor/Staff Initials: _____

Health Information Privacy Policies & Procedures

I acknowledge that I have been made aware of the Notice of Privacy Practices . I may receive a copy of the Notice of Privacy Practices if I request one. In addition to those described in the Privacy Policy, I give my permission for Ladd Dental Group, Inc. to discuss my health care and billing information with the following people:

Name: _____Relationship: _____

Name: _____Relationship: _____

This is effective until I notify Ladd Dental Group, Inc. of any changes

Date: _____ Patient/Guardian Signature: _____