Drews Dental Services, P.C.

Treating Your Mouth Like Our Own

www.mainedentalclinic.com

Welcome to our practice! We thank you for making us your choice and joining with us in caring for your dental health. By becoming our patient, you have created a partnership which we hope will last through the years.

Our partnership is prevention oriented and dedicated to your health. We are committed to providing superior dental care and are proud of our dedication to our patients. Our goal is to help you feel and look your best while focusing on long term dental health.

Our office hours are patient oriented and we are available for emergency services. Because communication is important, we will advise you of treatment needs and expenses in advance, even assist with your insurance filing. We are here to serve you, so please do not hesitate to contact us regarding any matter.

Your health, safety and well-being is our top priority, therefore if you have any medical conditions that could be impacted by dental treatment, which might include; diabetes, high blood pressure, artificial heart valves and/or joints, then please let us know in advance. Often this means you will need to pre-medicate with an antibiotic one hour prior to your appointment. If you have current radiographs, they must be forwarded to our office prior to your appointment. If we have to duplicate current x-rays, your insurance will not cover them a second time and you will be financially responsible for the fees incurred on the day of your appointment.

We also ask that you confirm your appointment with us either via text, 207-245-1493, or phone call, 207-782-5308, at least 24 hours prior to your appointment to avoid being removed from the schedule.

We welcome new patients and appreciate any referrals we might earn. Thank you for the privilege of allowing us to be a part of your dental care. If you would like to "meet" us before your appointment, or learn a bit more about the office, check out our website! We look forward to meeting you!

Best regards,

Dr. Peter Drews, D.D.S., M.A.G.D.

Dr. Kristina Lake Harriman, D.M.D.

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Patient Information

Name: _____
Address: _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Cell Phone: _____ Email: _____

Sex: ◯ M ◯ F Age: _____ Birthdate: _____ Social Security Number: _____

◯ Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced ◯ Domestic Partnership

Patient Employer: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Business Email: _____
Whom may we thank for referring you? _____
Notify in case of an emergency: _____ Home Phone: _____
Cell Phone: _____ Business Phone: _____ Email: _____

Primary Dental Insurance

Person Responsible for Account: _____
Relation to Patient: _____ Birthdate: _____ Social Security Number: _____
Address *(if different from patient):* _____ Home Phone: _____
City: _____ State: _____ Zip Code: _____
Cell Phone: _____ Email: _____
Responsible Party Employer: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Business Email: _____
Insurance Company: _____ Insurance Phone: _____
Insurance Email: _____
Contract Number: _____ Group Number: _____ Subscriber Number: _____
Name of dependents included in plan: _____

Secondary Dental Insurance

Is patient covered by additional insurance? ◯ Yes ◯ No
Subscriber Name: _____
Relation to Patient: _____ Birthdate: _____ Social Security Number: _____
Address *(if different from patient):* _____ Home Phone: _____
City: _____ State: _____ Zip Code: _____
Cell Phone: _____ Email: _____
Subscriber Employer: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Business Email: _____
Insurance Company: _____ Insurance Phone: _____
Insurance Email: _____
Contract Number: _____ Group Number: _____ Subscriber Number: _____
Name of dependents included in plan: _____

Dental History

Goal of today's appointment: _____
Are you in dental discomfort? ◯ Yes ◯ No If yes, please explain: _____
Former Dentist: _____ Address: _____
Dentist's Email: _____ Phone: _____
Date of last dental care: _____ Date of last x-rays: _____

Check (√) yes or no if you've had problems with any of the following:

◯	Y	◯	N	Bad breath	◯	Y	◯	N	Food collection between teeth	◯	Y	◯	N	Sensitivity to cold
◯	Y	◯	N	Bleeding gums	◯	Y	◯	N	Grinding or clenching jaw	◯	Y	◯	N	Sensitivity to hot
◯	Y	◯	N	Clicking or popping jaw	◯	Y	◯	N	Loose teeth or broken fillings	◯	Y	◯	N	Bite sensitive
◯	Y	◯	N	Periodontal treatment	◯	Y	◯	N	Sensitivity to sweets	◯	Y	◯	N	Sores or growths in the mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever had an adverse reaction during or in conjunction with a medical or dental procedure? ◯ Y ◯ N

Other information about your dental health or previous treatment? _____

Medical History

Primary Care Physician Name: _____ Phone: _____ Date of last visit: _____

Have you had any serious illnesses or operations? ◯ Y ◯ N

If yes, please explain: _____

Are you currently under physician care? ◯ Y ◯ N If yes, please explain: _____

Have you ever had a blood transfusion? ◯ Y ◯ N If yes, please give approximate dates: _____

Have you ever taken Fen-Phen/Redux? ◯ Y ◯ N

Have you ever used a bisphosphonate medication (i.e.: Fosamax, Actonel, Atelvia, Didronel, or Boniva)? ◯ Y ◯ N

Are you pregnant? ◯ Y ◯ N Nursing? ◯ Y ◯ N Taking birth control pills? ◯ Y ◯ N

Check (√) yes or no if you've ever had any of the following:

◯	Y	◯	N	AIDS/HIV positive	◯	Y	◯	N	Food allergies	◯	Y	◯	N	Pacemaker/ Heart surgery
◯	Y	◯	N	Anaphylaxis	◯	Y	◯	N	Glaucoma	◯	Y	◯	N	Psychiatric care
◯	Y	◯	N	Anemia	◯	Y	◯	N	Headaches	◯	Y	◯	N	Rapid weight gain or loss
◯	Y	◯	N	Arthritis. Rheumatism	◯	Y	◯	N	Heart murmur	◯	Y	◯	N	Radiation treatment
◯	Y	◯	N	Artificial heart valves	◯	Y	◯	N	Heart problems	◯	Y	◯	N	Respiratory disease
◯	Y	◯	N	Artificial joints		Describe:			_____	◯	Y	◯	N	Rheumatic/Scarlet fever
◯	Y	◯	N	Asthma	◯	Y	◯	N	Hemophilia or	◯	Y	◯	N	Shingles
◯	Y	◯	N	Atopic (allergy prone)					Abnormal bleeding	◯	Y	◯	N	Shortness of breath
◯	Y	◯	N	Back problems	◯	Y	◯	N	Herpes	◯	Y	◯	N	Skin rash
◯	Y	◯	N	Cancer	◯	Y	◯	N	Hepatitis	◯	Y	◯	N	Spina Bifida
◯	Y	◯	N	Chemical dependency	◯	Y	◯	N	High Blood pressure	◯	Y	◯	N	Stroke
◯	Y	◯	N	Chemotherapy	◯	Y	◯	N	Jaw pain	◯	Y	◯	N	Surgical implant
◯	Y	◯	N	Circulatory Problems	◯	Y	◯	N	Kidney disease or	◯	Y	◯	N	Swelling of feet or ankles
◯	Y	◯	N	Cortisone treatments					malfunction	◯	Y	◯	N	Thyroid disease or malfunction
◯	Y	◯	N	Cough, persistent	◯	Y	◯	N	Liver Disease	◯	Y	◯	N	Tobacco habit
◯	Y	◯	N	Coughing blood	◯	Y	◯	N	Material allergies	◯	Y	◯	N	Tonsillitis
◯	Y	◯	N	Diabetes					(**Latex**, wood, metal, chemicals)	◯	Y	◯	N	Tuberculosis
◯	Y	◯	N	Epilepsy	◯	Y	◯	N	Mitral valve prolapse	◯	Y	◯	N	Ulcer/Colitis
◯	Y	◯	N	Fainting	◯	Y	◯	N	Nervous problems	◯	Y	◯	N	Venereal disease

Current Medication List: _____

Medication Allergies: _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all the information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date: _____

Payment is due in full at the time of treatment, unless prior arrangements have been approved.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice take effect, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy policies, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Patient Signature: _____ Date: _____

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter at the end of this Notice. If you request copies, we will charge you $0.20 for each page, $20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary of an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your requests in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Peter J. Drews, D.D.S., M.A.G.D.
Telephone: 207-782-5308
Email: info@mainedentalclinic.com
Address: 471 Sabattus Street, Lewiston, Maine 04240

Patient Signature: _____ Date: _____

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PATIENT FINANCIAL POLICY

Welcome and thank you for choosing us to be your dental provider! It is important to us that you are perfectly comfortable and clear regarding fees and services.

Payment: We accept Visa, MasterCard, American Express and Discover. We also offer third party financing through CareCredit (ask our Financial Coordinator). All remaining portions of dental fees must be paid upon receipt of your statement.

Regarding Insurance: It's wonderful that you have dental insurance to cover part of the cost of your dental care. We want to cooperate with you to make the most effective use of your insurance benefits. As a courtesy to you, we accept assignment of insurance benefits. **However, we can only estimate what those benefits will be. We do require your estimated portion of the bill to be paid at the time of service.** Our practice is committed to providing the best treatment for our patients, and we charge what is typical, and in many cases, below typical, for our area.

We are a participating provider with several insurance companies, but accept most dental plans. Regardless of being in or out of network, you are responsible for any remaining fees after the insurance company has made payment. Your policy is a contract between you and your insurance company. We are not a party to that contract.

Insurance group policies vary greatly in their benefits to patients. Generally, the more you and your employer pay for the insurance, the more dental services the insurance will cover. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under your insurance plan. It is possible your insurance company will not pay 100% of their share of the fee.

All of our patients, insured or not, receive the highest quality of dental care and are charged the same fee. Every effort is being made to keep the cost of dental care down, therefore your prompt payment for dental services is appreciated.

Financial Charges: All returned checks are subject to $25 fee. All balances over 60 days are subject to $20 rebilling fee and $25.00 late charges toward overdue financial agreements. We have the option to report your balance with us to any credit reporting agency and credit bureau.

Past Due Accounts: In the event that your account is turned over to a Collection Agency or attorney, you agree to pay all fees including and not limited to attorney fees, court costs, and collection agency fees.

Missed Appointment Fee: Please note that there is a missed appointment fee of $60.00 for all appointments not given at least 24 business hours notice. Please give us a call in advance if you need to reschedule or cancel your appointment.

Transferring Records: You will need to request, in writing if you would like us to mail, fax, email, etc. any part of your records with Drews Dental Services. We need at least 8 working hours in advance to prepare your record to be transferred. We need at least 3 business days, if your record is more than two years old and is stored in a company's archive. The cost of duplicated/printed x-rays is $5.00 for a single PA x-ray, $15.00 for Bite-wings, $25.00 for a Full Mouth Series and $25.00 for a Panoramic film, Copying and printing fees are $10.00 per record. No fees are charged for emailed x-rays. The fee is waived if we are referring you to a specialist.

We hope this clarifies our office procedure regarding payment arrangements. If you have any questions, please feel free to speak with our Financial Coordinator.

Thank you for your support and cooperation.

Patient Signature: _____ Date: _____

PHOTO AND DIGITAL IMAGES CONSENT FORM

Dear Patient,

Occasionally, we take images of your teeth, smile and/or entire face. We may use them, or keep them on file, for insurance and/or liability reasons. Some dental cases are unique, and images can be very helpful to other patients trying to make a decision regarding their own dental treatment. We do not sign your name under the images.

By signing this form I agree to give Dr. Peter J. Drews, his associates, assistants and staff permission to take and use – free of charge – photos and digital images of me, and/or my dental work for internal office use, website and/or educational purposes. I understand that I may revoke permission to use the images of my likeness at any time by contacting Drews Dental Services, P.C., in writing.

Patient Signature: _____ Date: _____

DENTAL INSURANCE CLAIM PROCESSING POLICY

Because dental insurance companies have become increasingly difficult to work with, we have been forced to establish a policy which does not place us in a constant confrontational role.

It is your dentist's responsibility to recommend what you need. All recommendations are based on diagnostic (x-ray) and clinical pictures presented to you by your dentist or their staff. Your dentist will give you options, if any, for the treatment recommended, and will answer all questions you might have about it and will help you decide what treatment would be best for you.

When your office visit is completed, the receptionist will enter the charges into the computer. You will be asked to pay an estimated amount for the service provided. Our estimate is a guess based on the information you provided by the insurance representative over the phone. The information given to us is not a guarantee of payment or approval for the treatment recommended by your dentist.

If you carry a supplemental or secondary Insurance Plan, we will help you with both insurance claims, but we still follow our Policy to collect deductible, coinsurance, pre-payment. Your overpayment, if any, will be returned back to you after the secondary claim is cleared, in the form of original payment. **Initialize**

If you are interested in following the doctor's recommendation and need to know exactly how much your insurance plan will pay, a pre-treatment estimate will need to be filed. We will file a patient treatment pre-estimate to their primary insurance upon the patient's request before the treatment is begun. **Initialize**

We will send a dental claim on your behalf and will answer any questions your Insurance Company may raise about diagnosis or treatment in an appropriate, timely manner. It is important that you understand we are not part of the relationship between you and your Insurance. If insurance denies benefits for a patient's treatment for any reason, the patient is financially responsible for all charges and for any outstanding balance on the account. We are unable to "force" an insurance company to fulfill its obligation to you.

If the insurance company does not pay for your treatment in a reasonable period of time (more than two months), the patient is responsible to pay the remaining balance. All credits, if any, will be returned to the patient upon receipt of the payment from the insurance. _____ **Initialize**

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED FROM SERVICES RENDERED BY DREWS DENTAL SERVICES, P.C.

Print Name: _____ (Patient/Subscriber, if minor – a GUARDIAN)

Patient Signature: _____ Date: _____

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General Dentistry Informed Consent Form

EXAMINATION AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

DRUGS, MEDICTION AND SEDATION

I have been informed and understand that antibiotic, analgesics and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take prescribed medications in the manner prescribed may offer risks of continued or aggravated infection, pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

CHANGES IN TREATMENT PLAN

I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ)

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise I will be referred to a specialist for treatment, the cost of which is my responsibility.

FILLINGS

I understand care must be exercised when chewing on a filling during the first 24 hours to avoid breakage, and tooth sensitivity is a common after effect of a newly placed filling.

REMOVAL OF TEETH (EXTRACTIONS)

Alternative to removal, such as root canal therapy, crowns, periodontal surgery, etc., has been explained to me and, if needed, I authorize the Dentist to remove teeth and any others necessary for the reason in paragraph 3. I understand removing teeth does not always remove all infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parathesia) that can last for an indefinite period of time, or a fractured jaw. I understand I may need further treatment by a specialist, or even hospitalization, if complications arise during or following treatment, the cost of which is my responsibility.

CROWNS, BRIDGES, VENEERS AND BONDING

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand I may be wearing temporary crowns, which may come off easily and I must be careful to ensure they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crowns, bridge or cap, including shape, fit, size, placement and color, will be done before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which may not always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily procedures.

DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing those appliances have been explained to me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new denture, including shape, fit, size, placement and color will be during the “teeth in wax” try-in visit. I understand most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee root canal treatment will save my tooth. Complications can occur from the treatment and occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (i.e.:apicoectomy).

PERIODONTAL TREATMENT

I understand that periodontal disease is a serious condition causing gum inflammation and/or bone loss and it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

CONSENT

I understand that dentistry is not an exact science; therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I understand that no other Dentist, other than the treating Dentist, is responsible for my dental treatment.

Patient/Guardian Date

Witness Date