

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED

PATIENT'S NAME: _____

I certify that the answers which I have given to the questions concerning my health, if I am the patient, or the health of above-named patient, for whom I am responsible, are accurate and correct to the best of my knowledge. Since a change in medical condition or medications can affect dental treatment, I understand the importance of, and agree to notify the dentist of any such changes.

I authorize Dr. Bott, Dr. Hart, Dr. McDonald, Dr. Blackhurst/or Dr. Braithwaite and such associates as he/they designate, to perform procedures deemed necessary or advisable to maintain my dental health or the dental health of above-named patient, including arrangement for and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic endodontic or surgical treatments.

I understand that the administration of local anesthetic may cause reactions or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness and muscle soreness.

I do voluntarily assume any and all responsibility for any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with the general preventive, endodontic 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 the above-named patient. I acknowledge that the nature and purpose of the foregoing procedures and potential risks associated therewith have been explained to me if necessary, and that I have been given the opportunity to ask questions.

I understand and agree that my insurance is a contract between me and/or my employer and the insurance company and that my insurance is billed as a courtesy to me and that I am responsible for all unpaid balances after 30 days. Interest will be charged at the rate of 1.75% per month (21% per annum) on balances 30 days and older. In the event the balance is not paid, I, the undersigned as patient or as person responsible for the above-named patient, agree to pay the above-referenced interest, and all costs incurred in the collection of the account, including a collection cost of 40% of the principal amount, attorney's fees, and court costs. I further understand that a missed appointment fee of \$25-\$50 (depending on length of appointment) may be charged if, I, the undersigned patient or as person responsible for the above-named patient fail to provide 24 hours notice for a cancellation or no-show to an appointment.

SIGNATURE _____ DATE: _____
(Patient, legal guardian, person responsible or authorized agents of patient)

WITNESS: _____ DATE: _____