

# RANCHVIEW FAMILY DENTISTRY, P.A.

8600 N. MacArthur Blvd., Suit 140  
Irving, TX 75063  
972-869-9090

**Patient Name:** \_\_\_\_\_

**RECEIPT & ACKNOWLEDGEMENT:** My signature below represents my receipt, acknowledgement, understanding, and agreement with the following documents for myself or my child:

1. HIPAA Notice of Privacy Practices - x \_\_\_\_\_

2. Patient Financial Policy - x \_\_\_\_\_

## GENERAL CONSENT FOR DENTAL TREATMENT

As a patient you will at all times have access to current and complete information about your condition and will, unless otherwise specified, receive continuity of treatment, be provided an estimate of the cost, and receive dental care according to a properly sequenced plan of treatment. (Before receiving treatment you should ask the dentist or dental hygienist about the procedure(s) that he/she recommends you undergo, and ask any questions you may have before you decide whether or not to give your consent for the procedure(s) to be done.)

All dental procedures may involve risks of unsuccessful results and complications, and no guarantee is made as to result of care. You have the right at all times to be informed of any such risks as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risks of no treatment. You have the right to consent to or refuse any proposed procedure at any time prior to its performance.

**DIAGNOSTIC & PREVENTIVE SERVICES:** I understand the need for and consent to all necessary Diagnostic X-Rays, Cleaning of Teeth, Application of Topical Fluoride, & Placement of Sealants for myself or my child whenever deemed appropriate by the dentist. (If there is an estimated out-of-pocket expense to you for any preventive services, we will attain your approval again prior to placement.)

**DENTAL ANESTHETICS:** I understand the risks as well as the benefits associated with Topical Anesthetics and Local Dental Anesthetic Injections and hereby consent to their use whenever deemed appropriate by the dentist for any dental procedures including but not limited to Fillings, Root Planing & Scaling, Crowns Bridges, Dentures, and Root Canal Therapy for myself or my child.

**EMERGENCY CARE:** Emergency dental care treatment is intended to provide relief of severe pain and infection for individuals in acute need. You as a patient of record have access to a dental emergency service. There is a charge associated with this service.

**DENTAL RECORDS:** The dental medical record, radiographs (x-rays), photographs, videos, models and other diagnostic aids relating to your dental treatment are the property of Ranchview Family Dentistry, P.A. You have the right to inspect such materials and to request a copy of your dental medical records and radiographs. There is at least \$25.00 fee for copying these items. You may also requests to have your dental radiographs sent to another health care provider by signing a Release of Information form.

**Your signature on this form certifies that you have read and understand the information provided on the form, that you accept the dental care and treatment under the described terms and conditions.**

**Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Signature