OCEAN WAVES DENTISTRY

8532 Old C.R. 54 (Greenbrook Plaza)
New Port Richey, Florida 34653
(727) 372-9669 | www.oceanwavesdentistry.com

Photo & Video Release Form

I, _____ (printed name), grant Ocean Waves Dentistry, its representatives and employees the right to take photographs and/or videos of me in regards to the treatment and services I receive at their facility for the purpose of publication, promotion, or advertising in any manner or in any medium, including print or electronic.

I give permission to Ocean Waves Dentistry to copyright and use such photographs and/or videos with or without my name, for the purpose of advertising, illustration, web content, and publicity without restriction. I understand that I will not receive any compensation for the use of such photographs or videos taken.

I acknowledge that I have read and agree to the above photograph and video release form

Signature of Patient or Parent/Guardian (if under 18):_____

Address:_____

_____

Date:_____

I acknowledge that I have read the above photograph and video release form and decline

Signature of Patient or Parent/Guardian (if under 18):_____

Address:_____

_____

Date:_____

Use and Disclosure of Personal Information

I understand that I have certain rights to privacy regarding my protected health information, including my signature. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Your information is necessary for us to:

1. Process all insurance claims;
2. Ensure payment for services provided
3. Release medical information to insurance companies needed for the processing of your claims
4. Release information to other medical and dental providers, including laboratories, when necessary, for your treatment.

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to laboratories that require my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Maria Claudia Alvarado. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original

Patient name (printed):_____

Signature of Patient or Parent/Guardian (if under 18):_____

Date:_____

Notice of Deemed Consent for HIV, HPB, and HPC Testing

If one of our health care professionals, workers, or employees should be directly exposed to your blood or bodily fluids in a way that may transmit disease, your blood will be tested for infection of Human Immune Deficiency Virus (HIV, the AIDS virus). The blood will also be tested for the presence of Hepatitis B & Hepatitis C viruses. A physician or other health care provider will notify you, and that individual, the results of the test and provide counseling, if necessary.

If you should be directly exposed to blood or bodily fluids in a way that may transmit disease, the individual's blood will be tested for infection of Human Immune Deficiency Virus (HIV, the AIDS virus). The blood will also be tested for the presence of Hepatitis B & Hepatitis C viruses. A physician or other health care provider will notify you, and that individual, the results of the test and provide counseling, if necessary.

The Notice of Deemed Consent for Testing has been explained to me. I have received a copy and I accept the terms. For Patients under 18 years of age, the responsible party's signature authorizes any necessary testing.

Patient name (printed):_____

Signature of Patient or Parent/Guardian (if under 18):_____

Date:_____

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Informed Consent for All Treatment

1. **EXAMINATIONS AND X-RAYS**
   I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the treatment plan

   Initials_____

2. **DRUGS, MEDICATION AND SEDATION**
   I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have informed the Dentist of any known allergies. They may cause drowsiness, 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 to me in the office for my care. I understand that failure to take medications prescribed to me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

   Initials_____

3. **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 the teeth that were not discovered in the prior examination, the most common being root canal therapy following routine restorative procedures. I give permission to the Dentist to make any/all changes and additions as necessary.

   Initials_____

4. **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)**
   I understand that 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. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

   Initials_____

Patient name (printed):_____

Signature of Patient or Parent/Guardian (if under 18):_____

Date:_____

Informed Consent for Specific Treatment

5. FILLINGS

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

Initials_____

6. REMOVAL OF TEETH (EXTRACTION)

Alternatives to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorize the Dentist to remove the teeth explained to me in the treatment plan. I understand removing teeth does not always remove the entirety of the 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, spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time or fractured jaw. I understand that 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.

Initials_____

7. CROWNS, BRIDGES, VENEERS AND BONDING

a. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may require a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

Initials_____

b. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

Initials_____

8. 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 the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary late. This is not included in the initial denture fee. I understand that 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. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

Initials_____

9. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment. Occasionally, canal material may extend through the root tip, which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand the endodontic files and reamers are very fine instruments and stress can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicectomy). I understand that the tooth may be lost in spite of all efforts save it.

Initials_____

10. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that 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 any treatment depends in part on my efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restorative work.

Initials_____

11. BLEACHING

Bleaching is a procedure done either in office (approximately 1 hour) or with take home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which will subside when treatment is discontinued. The Dentist may prescribe fluoride treatments for rare cases of persistent sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

Initials_____

12. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentists's recommendation of optimal dental treatment

Initials_____

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment 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 also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature of Patient or Parent/Guardian (if under 18):_____

Date:_____

Financial Policy Agreement

Concerning Your Dental Benefits:
Dental insurance is a contract between you and the insurance company. Despite our efforts, there is no guarantee of benefits or reimbursement. As a courtesy, we will bill your insurance company on your behalf.

Insurance co-payment and/or a deductible payment is the patient's responsibility. We verify insurance benefits as a courtesy to you. This is not a guarantee of payment from your insurance company. After your claim is processed, it is possible your balance will be different than our estimate.

Concerning Your Appointments:
We try to confirm appointments with a telephone call in advance as a reminder. Please return these calls to hold your appointment day and time. If an appointment is canceled with less than 24 hours' notice, a broken appointment fee of $50 will be charged to you for canceling a visit scheduled with your dental hygienist. If the appointment was scheduled with a dentist the broken appointment fee will be $100.

Guaranty of Payment:
By signing below, I accept personal responsibility for the payment in full of my account.

Signature of Patient or Parent/Guardian (if under 18):_____

Date:_____