MILLER GENERAL DENTISTRY

Craig D. Miller, D.D.S., P.A.

**GENERAL CONSENT FORM**

**SECTION A: PATIENT INFORMATION**

Patient Name: Date of Birth: SSN:

 **SECTION B: CONSENT TO TREATMENT**

I do hereby authorize and request the performance of dental services and the use of whatever procedures Dr. Miller may deem necessary for my treatment. I understand that Dr. Miller and his staff will use clinical and patient management techniques that are reasonable, necessary and advisable. I also authorize the administration of anesthetics or analgesics that may be deemed appropriate by Dr. Miller. I understand that the purpose for using local anesthetics may be therapeutic, diagnostic, or for the treatment of facial pain. I understand that potential complications include but are not limited to pain, swelling, bruising, temporary limited opening and local infection. I understand that in occasional cases that the anesthesia may be prolonged and in very rare cases permanent.

I understand that I am responsible for obtaining any current x-rays that may have been taken at a previous office.

I understand that any treatment plans presented, along with fees outlines, could change depending on the time elapsed since the initial examination and extent of dental pathology. Occasionally, once the treatment plan has been started, complications may arise that dictate additional procedures or treatment. Dr. Miller and his staff will always advise me of any changes.

In the event that Dr. Miller or a staff member is exposed to my blood or other bodily fluids, I agree to have my blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C virus (HCV), and the human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and that person would be advised of my rights regarding protected health information.

 **SECTION C: FINANCIAL RESPONSIBILITY**

I agree to be responsible for full payment of all charges for dental services performed on me. If for any reason the insurance company does not pay its estimated portion, I agree that I will be responsible for the account balance. *I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers.* In the event that my account is placed with a third party collection agency or attorney, I will be assessed any fees relating to this action. *I UNDERSTAND THAT ANY APPOINTMENT BROKEN WITHIN 24 HOURS IS SUBJECT TO A MISSED APPOINTMENT FEE OF $75.*

 **SECTION D: SIGNATURE**

Patient Signature: Date:

If the patient is a minor, or if this Consent is signed by a personal representative on behalf of the patient, please complete the following:

 Signature of Parent, Guardian or Personal Representative:

 Printed name: Relationship to patient:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.