Eaglesoft Medical History

Patient Name: John S Doe **Birth Date:** 2/21/2015

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	**YES**
Have you ever been hospitalized or had a major operation?	No
Have you ever had a serious head or neck injury?	No
Are you taking any medications, pills, or drugs?	No
Do you take, or have you taken, Phen-Fen or Redux?	No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	No
Are you on a special diet?	**YES**
Do you use tobacco?	No
Do you use controlled substances?	No

Women: Are you...

Pregnant/Trying to get pregnant?	No	Nursing?	**YES**	Taking oral contraceptives?	**YES**

Are you allergic to any of the following?

Aspirin	No	Codeine	No	Metal	No	Sulfa Drugs	No
Penicillin	No	Acrylic	**YES**	Latex	No	Local Anesthetics	No

Other? **YES**

Do you have, or have you had, any of the following?

AIDS/HIV Positive	No	Arthritis/Gout	No	Blood Transfusion	**YES**	Chest Pains	No
Cortisone Medicine	No	Epilepsy or Seizures	No	Frequent Diarrhea	No	Heart Attack/Failure	No
Hemophilia	**YES**	High Cholesterol	No	Leukemia	**YES**	Osteoporosis	No
Radiation Treatments	**YES**	Scarlet Fever	No	Stomach/Intestinal Disease	No	Tuberculosis	No
Alzheimer's Disease	No	Artificial Heart Valve	No	Breathing Problems	No	Cold Sores/Fever Blisters	No
Diabetes	No	Excessive Bleeding	No	Frequent Headaches	No	Heart Murmur	No
Hepatitis A	No	Hives or Rash	No	Liver Disease	No	Pain in Jaw Joints	No
Recent Weight Loss	No	Shingles	No	Stroke	No	Tumors or Growths	No
Anaphylaxis	No	Artificial Joint	No	Bruise Easily	No	Congenital Heart Disorder	No
Drug Addiction	No	Excessive Thirst	No	Genital Herpes	No	Heart Pacemaker	No
Hepatitis B or C	No	Hypoglycemia	No	Low Blood Pressure	No	Parathyroid Disease	No
Renal Dialysis	No	Sickle Cell Disease	No	Swelling of Limbs	No	Ulcers	No
Anemia	No	Asthma	**YES**	Cancer	No	Convulsions	No
Easily Winded	No	Fainting Spells/Dizziness	No	Glaucoma	No	Heart Trouble/Disease	No
Herpes	No	Irregular Heartbeat	No	Lung Disease	No	Psychiatric Care	No
Rheumatic Fever	No	Sinus Trouble	No	Thyroid Disease	No	Venereal Disease	No
Angina	No	Blood Disease	No	Chemotherapy	No	Yellow Jaundice	**YES**
Emphysema	No	Frequent Cough	No	Hay Fever	No		
High Blood Pressure	No	Kidney Problems	No	Mitral Valve Prolapse	No		
Rheumatism	No	Spina Bifida	No	Tonsillitis	No		

Have you ever had any serious illness not listed above?	No

Comments:

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient`s) health. It is my responsibility to inform the dental office of any changes in medical status.

Date of signing	2/21/2024
Signature Of	Patient, Parent or Guardian
Name	Jane Roe
IP Address	127.0.0.1

Signature

Date of signing	2/21/2024
Relationship to the patient	Guardian
Name	Jane Roe
IP Address	127.0.0.1

Established Patient ONLY-MEDICAL HISTORY UPDATE

Patient Name: John S Doe **Birth Date:** 2/21/2015

Mission Hill Dental

830-625-7322 Phone

830-620-5709 Fax

contact@missionhilldental.com

Established Patient ONLY-MEDICAL HISTORY UPDATE

Reason for today's Visit:	
Any change in health since last dental visit?	No
Any surgeries or hospitalizations since last dental visit?	**YES**
Any bleeding disorders?	No
Any bone treatments?	No
Are you taking any medications?	No
I certify that I have read and I understand the questions above. I acknowledge that I will not hold my doctor, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.	No

Signature

Date of signing	2/21/2024
Relationship to the patient	Guardian
Name	Jane Roe
IP Address	127.0.0.1

Extractions, Crowns, Dentures & Root Canal Tx Consent

Patient Name: John S Doe **Birth Date:** 2/21/2015

MISSION HILL DENTAL

Horacio Lucero, D.D.S.

2732 Big Oak

New Braunfels, Texas 78132

830-625-7322 Phone

830-620-5709 Fax

www.missionhilldental.com

1. Drugs And Medications

I 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 (severe allergic reaction).

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 during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the necessary teeth and any others necessary for reasons in paragraph **#2**. I understand removing teeth does not always remove all 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, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months), or 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.

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 the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and

possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the 'teeth in wax" try-in visit. 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 realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that 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 (apicoectomy).

I understand that I am having the following work done:	
I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully 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 have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.	No

Signature

Date of signing	2/21/2024
Relationship to the patient	Guardian
Name	Jane Roe
IP Address	127.0.0.1

Financial Policies

Patient Name: John S Doe **Birth Date:** 2/21/2015

Mission Hill Dental

Dr. Horacio Lucero

2732 Big Oak

New Braunfels, TX 78132

Financial Policies

PAYMENT IS DUE AT THE TIME OF SERVICE. **We accept cash, personal check, and all major credit cards.** We require you to pay your estimated cost share at the time services are rendered. Any remining balance will be billed to you once your insurance company has processed your claim. If any amount is left unpaid and collection fees are incurred, these additional fees will be added to the patient's account balance and become the responsibility of the patient or guardian on the account.

If you have insurance coverage, the insurance information must be supplied at the time of service. We will file up to 2 insurance claims, primary and secondary, as a courtesy for you. **You are responsible for any non-covered items or services. Not all services and supplies are covered by insurance. If you are not clear on the coverage and benefits of your plan, please call you insurance company to inquire what your out of pocket expenses will be for the services you receive.** Your policy is between you and your insurance company and coverage varies per policy, we cannot be involved in disputes over non-covered services or supplies. If your insurance had not paid out claim within 45 days from the date of service, we ask that you call your insurance company to expedite payment. After 60 days of non-payment, you will become responsible for the balance.

CANCELLATION POLICY: Please give 24-hour advanced notice if you are unable to keep an appointment so that we may open a slot for other patients in need. Failure to do this will result in a $55 cancellation fee.

Please read and sign:

I will be responsible for any supplies or services which are provided to me.

I have been provided an opportunity to review the Notice of Privacy Practices regarding this office's HIPPA compliance.

I also have read the financial and cancellation policies listed above and agree to these terms.

Signature

Date of signing	2/21/2024
Relationship to the patient	Guardian
Name	Jane Roe
IP Address	127.0.0.1

HIPPA-Authorization to Release Information

Patient Name: John S Doe **Birth Date:** 2/21/2015

Mission Hill Dental

Dr. Lucero and/or his staff will not release dental information to or discuss dental information with anyone except the following people listed below unless permission is given in writing.

Notice of Privacy Practice:

I herby acknowledge that I have been presented with a copy of Dr. Lucero's Notice of Privacy Practice and that I have read and understand my rights.

Name: Relationship: Phone number:	
Name: Relationship: Phone number:	
Name: Relationship: Phone number:	
I understand the terms and authorize the practice to disclose my medical information to those parties as mentioned here.	No

Signature

Date of signing	2/21/2024
Relationship to the patient	Guardian
Name	Jane Roe
IP Address	127.0.0.1

Implant Consent Form

Patient Name: John S Doe **Birth Date:** 2/21/2015

MISSION HILL DENTAL

Horacio Lucero, D.D.S.

2732 Big Oak

New Braunfels, Texas 78132

830-625-7322 Phone

STATEMENT OF CONSENT FOR TWO-STAGE ENDOSTEAL OSTEOINTEGRATED IMPLANTS

I hereby authorize Dr. Lucero, and any other agents or employees of and such assistants as may be selected by any of them, to perform surgery upon me (or upon the person identified below was the patient, for whom I am empowered to consent), to insert a two-stage endosteal osteointegrated implant in my upper and/or lower jaw.

I understand incision (s) will be made inside my mouth for the purpose of placing one or more endosteal metal room form structures in my jaw (s) to serve as anchor (s) for a missing tooth or teeth or to stabilize a crown (cap), denture or bridge. I acknowledge that Dr. Lucero has explained the procedure, including the number and location of the incisions to be made, in detail. I understand that the crown (cap), denture or bridge will later be attached to this implant by Dr. Lucero and the cost for that work is not included in the charge for this procedure. I also understand that this implant should last for many years, but that no guarantee that it will last for any specific period of time can be or has been given. I have been informed that the implant must remain covered under the gum tissue for at least three months before it can be used and that a second surgical procedure is required to uncover the top of the implant. I also understand that there will be no refund of the fees in the event of failure. It has also been explained to me that once the implant is inserted, the entire dental treatment plan, including my personal oral hygiene, must be followed and completed on my schedule. If this schedule is not carried out, the implant may fail.

I have been informed of the alternatives to use of an osteointegrated implant, including no treatment at all; construction of a new ridge of my upper or lower jaw by means of vestibuloplasty (plastic surgery on

gums), skin and bone grafting or with synthetic materials; and implantation of another type of device. The advantages and disadvantages of each of the above procedures have been explained to me and I choose to proceed with insertion of the osteointegrated implant.

I also authorize and direct Dr. Lucero and his associates or assistants to provide such additional services as he/she or they may deem reasonable and necessary, including, but not limited to, the administration of anesthetic agents; the performance of necessary laboratory, radiological (x-ray), and other diagnostic procedures; the administration of medications orally, by injection, by infusion, or by other medically accepted route of administration; and the removal of bone, tissue, and fluids for diagnostic and therapeutic purposes and the retention or disposal of same in accordance with usual practices. If any unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated and I am under any form of sedation or anesthesia, I further authorize and direct whatever is deemed necessary and advisable under the circumstances with the exception of _____ (if none, put ”none”). Prior to performing such additional or different procedures, however, I desire that they be discussed with _____ (relationship: _____), whom I hereby authorize and designate to give consent to treatment on my behalf whenever possible.

I understand that there are risks associated with this procedure and these have been explained to me. They may include, but are not limited to, swelling; damage to and possible loss of other teeth, fillings or other dental work; infection or abscess; pain; significant bleeding which may be heavy or prolonged; sinus or nasal problems or infection; poor healing; loss of bone; fracture of the jaw; injury to nerves near the treatment site which may cause pain, numbness or tingling of the lips, chin, face, mouth, teeth and tongue (which is usually temporary but may be permanent); loss of or damage to the ability to taste; stretching of the corners of the mouth which resultant cracking and bruising; accidental opening and infection of the normal sinus cavity located above the upper teeth. Although a good cosmetic result is hoped, it cannot be guaranteed. I also understand that any of these treatment complications may necessitate additional medical, dental or surgical recuperation at home or even in the hospital. Finally, I have been told that this treatment may not be successful, that problems may arise during the procedure which may prevent placement of the implant, and that rejection of this implant is possible which would necessitate its removal. Should this happen, I understand that it may be possible to insert another implant after a suitable healing period and that a charge will be made for this procedure.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO THE OPERATION AND THE EXPLANATION REFERRED TO OR MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND ALSO STATE I READ AND WRITE ENGLISH.	No

Signature

Date of signing	2/21/2024
Relationship to the patient	Guardian
Name	Jane Roe
IP Address	127.0.0.1

Insurance Info

Patient Information

First Name	John
Last Name	Doe
Middle Initial	S

Primary Insurance

Do you have dental insurance or will you be paying for yourself?	I have dental insurance
Company Name	Delta Dental
Type of plan	Dental Insurance
Subscriber Id	22244-34-1999
Group Number	324-765
Medicaid Id	

Insured

First Name	John
Last Name	Doe
Date of Birth	
Social Security Number	
Driver's License	
Address	
Address 2	
City	
State	
Zip	

Employer

Is the plan through an employer?	Yes
Company Name	RevenueWell
Address	2275 Half Day Rd
Address 2	ste 220
City	Bannockburn
State	IL
Zip	60015

Secondary Insurance

Do you have secondary dental insurance?	No
Company Name	
Type of plan	
Subscriber Id	
Group Number	
Medicaid Id	

Insured

First Name
Last Name
Date of Birth
Social Security Number
Driver's License
Address
Address 2
City
State
Zip

Employer

Is the plan through an employer?
Company Name
Address
Address 2
City
State
Zip

Signature

Date of signing	2/21/2024
Relationship to the patient	Guardian
Name	Jane Roe
IP Address	127.0.0.1

Primary Insurance Card

Secondary Insurance Card

Notice of Privacy Practice

Patient Name: John S Doe **Birth Date:** 2/21/2015

Mission Hill Dental Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMTION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

· basis for planning your care and treatment

· means of communication among the many health professionals who contribute to your care

· legal document describing the care you received

· means by which you or a third party payer can verify that services billed were actually provided

· a tool in educating health professionals

· a source of data for medical research

· a source of information for public health officials charged with improving the health of the nation

· a source of data for facility planning and marketing

· a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

· ensure its accuracy

· understand who, what, when, where and why others may access your health information

· make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

· request a restriction on certain uses and disclosures of your information

· obtain a paper copy of the notice of information practices upon request

· inspect and copy your health record

· amend your health record

· obtain an accounting of disclosures of your health information

· request communications of your health information by alternative means or at alternative locations

· revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

This organization is required to:

· maintain the privacy of your health information

· provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you

· notify you if we are unable to agree to a requested restriction

· accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

Signature

Date of signing	2/21/2024
Relationship to the patient	Guardian
Name	Jane Roe
IP Address	127.0.0.1

Oral Sedation Information & Consent

Patient Name: John S Doe **Birth Date:** 2/21/2015

Mission Hill Dental

Horacio Lucero, D.D.S., P.A.

(830) 625-7322

ORAL SEDATION INFORMATION & CONSENT

Triazolam (Halcion), although usually prescribed as a sleeping pill, is a medication that can greatly minimize anxiety that may be associated with going to the dentist. In a relaxed state, you will still be able to communicate with the dentist while treatment is being performed. Even though it is safe, effective and wears off rapidly after the dental visit, you should be aware of some important precautions and considerations.

1. This **consent** form and the dental treatment consent form should be signed **before** you take this medication. They are invalid if signed after you take the pills.

2. The onset of **Triazolam** is 15-30 minutes. **Do not drive after you have taken the medication.** The peak effect occurs between 1 and 2 hours. After that, it starts wearing off and most people feel normal after 6-8 hours. **For safety reasons and because people react differently, you should not drive, operate machinery, or climb stairs the remainder of the day.**

3. This medication should **not** be used if:

* You are hypersensitive to benzodiazephines (Valium, Ativan, Versed, Etc.)

* You are pregnant or breastfeeding

* You have liver or kidney disease

* You have acute narrow angle glaucoma

Tell the doctor if you are taking the following medications as they can adversely interact with Triazolalm: nefazodone (Serzone); cimetidine (Tagamet, Tagamet HB, Novocimetine, or Peptol); levadopa (Dopar or Larodopa) for Parkinson's disease; antihistamines (such as benedryl and travist); verapamil (calan); diltiazem (cardizem); erythromycin and the azole antimycotics (nizoral, biaxin, or sporanox); HIV drugs indinavir and nelfinovir; and alcohol. Of course taking recreational/illicit drugs can also cause untold reactions.

4. Side effects may include light-headedness, headache, dizziness, visual disturbances, amnesia, and nausea. In some people, oral Traizolam may not work as desired.

5. No smoking 12 hours before surgery or 48 hours after surgery. Smokers may notice a decrease in the medication's ability to achieve desired results.

6. You should not eat heavily prior to your appointment. You may take the medication with a small amount of food, such as juice, toast, etc. Taking it with too much food can make absorption into your system unpredictable.

7. You should not have alcohol or caffeine 24 hours prior to your appointment.

8. Do not wear contact lenses on the day of the procedure. Wear loose, short sleeve, comfortable clothing.

9. Have ice packs available to reduce swelling for the day of surgery only.

10. For 48 hours after surgery you will be on a cold liquid diet only. Items such as ice cream, yogurt, jello, fruit juices, and applesauce are appropriate. Supplement shakes like Ensure, Boost, and Slim Fast are also good.

11. If taking aspirin, or any form of blood thinner, consult with your physician prior to your appointment.

12. On the way home from the dentist, your seat in the car should be in a recline position. When at home, lie down with your head slightly elevated. Someone should stay with you for the next several hours because of possible disorientation and possible injury from falling. **An escort is required to bring you to the appointment and to take you home.**

13. Once you arrive home, you should keep hydrated and **call the office upon your arrival**.

14. **Family members and/or friends are not permitted in the operatory during surgery.**

15. The prescription you pick up from the pharmacy is an **additional fee** that is not included on the treatment plan given to you from our office.

I understand these considerations and am willing to abide by the conditions stated above. I have had an opportunity to ask questions and have had them answered to my satisfaction.

Signature

Date of signing	2/21/2024
Relationship to the patient	Guardian
Name	Jane Roe
IP Address	127.0.0.1

Patient Info

Patient Personal Information

First Name	John
Last Name	Doe
Middle Initial	S
Preferred Name	
Date of Birth	10/24/2004
Marital Status	Single
Gender	Male
Social Security #	
Driver's License	

Patient Contact Information

Home Phone #	
Cell Phone #	
Work Phone #	
Email Address	
Address	
Address 2	
City	
State	
Zip	

Patient Communication Preferences

Email	No
Text message	Yes

Responsible Party Personal Information

Who is the responsible party?	Guardian
First Name	Jane
Last Name	Roe
Middle Initial	
Preferred Name	
Date of Birth	
Social Security #	
Driver's License	

Responsible Party Contact Information

Home Phone #
Cell Phone #
Work Phone #
Email Address
Address
Address 2
City
State
Zip

Responsible Party Communication Preferences

Email	Yes
Text message	No

Insurance Notice

Please don't forget to bring your insurance card if this is your first appointment with us OR if your insurance information has changed.

Signature

Date of signing	2/21/2024
Relationship to the patient	Guardian
Name	Jane Roe
IP Address	127.0.0.1

Periodontal Treatment Consent

Patient Name: John S Doe **Birth Date:** 2/21/2015

CONSENT TO PERIODONTAL TREATMENT

This informed consent and authorization is given to Dr. Lucero, hereinafter referred to as doctor, after having first had a full explanation of the nature of the proposed treatment, the alternatives, and the risks.

Doctor has advised me that from the full dental examination that I have received, I have the following condition: Gingivitis/Periodontal Disease with attachment loss/Gingival Hyperplasia.

I hereby authorize and consent to doctor and whomever he or she may designate, to perform the following procedures: Periodontal Scaling and Root Planing.

Alternative Treatments. In making the above recommendation, Doctor has advised me that alternative treatments exist, which may include, but are not necessarily limited to: periodontal referral and or surgery.

Treatment Risks. I also understand that inherent to any procedure, and because of an individual's variations, certain risks are involved with this treatment. These may include, but are not necessarily limited to: swelling, pain, hot or cold tooth sensitivity, gum recession, bad breath, inability to perform adequate oral hygiene, loosening of teeth, abscesses or infection, pain, poor chewing, tooth sensitivity, tooth movements, worsening of periodontal disease condition, and deeper pocketing.

I also understand that the proposed treatment contains no guarantee, or warranty of success. Each individual case is unpredictable, making it impossible to surmise results. I further understand that the results may not be to my complete and full satisfaction after the treatment and that my condition may be the same, better, or worse after treatment.

I have received a full and complete opportunity to ask questions about the proposed treatment and all questions that I have asked have been answered to my complete satisfaction before I signed this form.

I understand that for successful periodontal results and to lessen the dangers of complication, the following treatment conditions are required or me; compliance with my individualized maintenance program; excellent oral hygiene; strict adherence to instructions in the wear of any appliances; and cooperation in keeping appointments.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE AUTHORIZATION THAT I AM ABOUT TO SIGN FOR THE PROPOSED TREATMENT, MEDICATION, OR SURGERY, DESCRIBED ABOVE. I ACCEPT THE RISKS OF SUBSTANTIAL HARMS, IF ANY, IN HOPES OF OBTAINING THE DESIRED BENEFICIAL RESULT OF THIS TREATMENT OR PROCEDURE. I FURTHER ACKNOWLEDGE THAT ALL BLANKS ON THIS FORM, REQUIRING COMPLETION, HAVE BEEN FILLED IN, OR DELETED, IF NECESSARY, PRIOR TO MY SIGNING THIS FORM.	No

Signature

Date of signing	2/21/2024
Relationship to the patient	Guardian
Name	Jane Roe
IP Address	127.0.0.1

Minor Consent

Patient Name: John S Doe **Birth Date:** 2/21/2015

Mission Hill Dental

AUTHORIZATION FOR DENTAL TREATMENT OF MINORS

I/We, being the parent(s) or legal guardian(s) of the above named minors(s), do hereby:

Authorize patient to obtain treatment unaccompanied by an adult

☐Understand that payment may be due and I will be billed accordingly

☐Acknowledge there have been no health changes. I understand it is my obligation to notify the dental office of any health changes prior to my child's appointment.

Name of Minor: DOB: Allergies/Special Conditions:
Name of Minor: DOB: Allergies/Special Conditions:
Name of Minor: DOB: Allergies/Special Conditions:

Signature

Date of signing	2/21/2024
Relationship to the patient	Guardian
Name	Jane Roe
IP Address	127.0.0.1