Milford
FAMILY Dentistry
Jordan L. Campbell, D.D.S. & Jacob A. Amato, D.D.S. 513.248.1233

REASON FOR TODAY'S VISIT (CHECKUP, TOOTHACHE, ETC)

TIME SINCE LAST DENTAL EXAM:

REGARDING DENTAL WORK IN GENERAL, ARE YOU APPREHENSIVE?
□ NO □MODERATELY □ VERY □TERRIFIED

CONSENTS:

I AUTHORIZE MILFORD FAMILY DENTISTRY TREAT ME, MY CHILD, OR NAMED PATIENT FOR WHICH I AM GUARDIAN. I UNDERSTAND THAT THERE ARE MEDICAL RISKS ASSOCIATED WITH ANY TREATMENT AND THAT LOCAL ANESTHETICS (NOVACAINE) WHICH MAY BE USED FOR TREATMENT CAN HAVE SIDE EFFECTS, INCLUDING BUT NOT LIMITED TO SUCH EFFECTS AS SHAKINESS, NERVOUSNESS, ALLERGIC REACTIONS OR FAINTING. I CONSENT TO THE TREATMENT MILFORD FAMILY DENTISTRY HAS RECOMMENDED AND REALIZE THAT THERE MAY BE CONSEQUENCES TO AN ALTERNATIVE TREATMENT OR NO TREATMENT AT ALL.

DATE_____ SIGNATURE_____

I HEREBY AUTHORIZE MILFORD FAMILY DENTISTRY TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY DENTAL DIAGNOSIS AND TREATMENT AND HEREBY ASSIGN TO THEM ALL PAYMENTS FOR DENTAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I ALSO PERMIT A COPY OF THIS SIGNATURE TO BE HELD ON FILE AND USED IN PLACE OF THE ORIGINAL FOR INSURANCE PURPOSES.

MANY INSURANCE COMPANIES RESERVE THE RIGHT TO DOWNGRADE FILLINGS, ONLAYS, CROWNS, AND SOME OTHER PROCEDURES TO A LOWER COST TREATMENT OPTION. WE PROVIDE THE BEST TREATMENT OPTIONS FOR YOUR INDIVIDUAL NEEDS AND IN THIS CASE YOU WILL BE RESPONSIBLE FOR ANY COST DIFFERENCES FROM OUR INITIAL TREATMENT PLAN ESTIMATES.

DATE_____ SIGNATURE_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (CAN BE PROVIDED UPON REQUEST):

I, OR MY CHILD HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

DATE_____ SIGNATURE_____