DENTAL CARE
INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I authorized dental treatment including necessary or advisable examination, radiographs (x-rays), and intraoral/extraoral images. In general, dental treatment may include but is not limited to one or a number of the following:

- Administration of local anesthesia
- Cleaning of teeth and application of topical fluoride
- Scaling and root planning with local anesthesia
- Treatment of diseased or injured teeth with dental restorations.
- The replacement of missing teeth with a dental prosthesis (crowns, bridges, partials, denture, etc.)
- Treatment of diseased or injured oral tissues (hard and/or soft tissues).
- Treatment of malposed (crooked) teeth and/or developmental abnormalities

*There are other dental treatments such as oral surgery, dental implant surgery, and root canal therapy that will have their own detailed consent forms.

_____ _____ _____

Patient Name Patient signature Date

Notice of Privacy Practices

Authorization of PHI Disclosure (Protected Health Information):

The information described above may be disclosed to the following recipients:

Name of person #1 _____ Relationship to you: _____

Name of person #2 _____ Relationship to you: _____

By signing below, I am acknowledging that I have received a copy of TNT Dental Care's Notice of Privacy Practices. I am also giving TNT Dental Care consent to disclose my protected health information to the person(s) listed above until such time a new *Acknowledgement of Receipt of Notice of Privacy Practices* and *Consent Form* is completed by me. I also understand and agree to the terms of this authorization.

_____ _____

Patient Signature Date

** You May Refuse to Sign This Acknowledgement **

☐ Individual refused to sign