Weatherford Pediatric Dental Associates

Dr. Brian Westfall

GENERAL INFORMED CONSENT FOR DENTAL PROCEDURES AND ANESTHESIA

This is my consent for Dr. Brian Westfall or any other physician who may be necessary, to perform the oral, maxillo-facial, and/or dental procedures indicated on my examination chart and any other procedure deemed necessary as a corollary to the planned sedation, and/or ultra light general anesthesia depending upon the judgment of the doctors involved in my care.

I have been informed and understand that occasionally there are complications that can occur with any dental procedure, including surgery, anesthesia, and or medications. These include but are not limited to the following:

- Post operative discomfort and swelling
- Heavy bleeding that may be prolonged
- Post operative infection requiring additional treatment
- Bruising or discoloration at the injection site
- Injury to the nerve underlying the teeth resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the treated site; this may persist for weeks, months, or in remote instances, permanently
- Stiffening of the neck and facial muscles
- Restricted mouth opening for several days or weeks
- Thrombophlebitis (inflammation of a vein) from intravenous and intramuscular injections
- TMJ injury secondary to treatment, especially when TMJ symptoms pre-exist
- Change in occlusion
- Injury to the adjacent teeth, restorations in other teeth, and injury to other tissues
- Referred pain to the ear, neck and head
- Nausea and vomiting, allergic reaction, cardiovascular collapse or other conditions requiring hospitalization
- Oral/sinus openings with delayed healing and possibly requiring additional surgery
- Decision to leave a small piece of root in the jaw when its removal would require extensive surgery

Anesthetics, medications, and prescriptions may cause drowsiness and lack of coordination, which can be decreased by the use of alcohol or other drugs. I have been advised not to operate any vehicle or hazardous device for at least 24 hours or until fully recovered from the effect of the anesthetic or medications that may have been given to me for my care.

During the course of my treatment, unforeseen conditions may be revealed that necessitate an extension of the original procedure or a different procedure than first planned. I therefore authorize and request Dr. Brian Westfall and their assistants to perform such procedures as are necessary and desirable in the exercise of their professional judgment. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known at the time the original procedure is commenced.

All post operative instructions will be explained to me along with receiving written instruction. I will arrange for a post operative visit if necessary and I understand that a perfect or cure is not guaranteed or warranted and cannot be guaranteed or warranted. I also understand that I may ask for a full recital of all possible risks attendant to phases of my care by just asking.

If you have any complaints you may contact the Texas State Board of Dental Examiners, (TSBDE), at 333 Guadalupe, Tower 3, Suite 800, Austin, TX 78701-3942 or you can call TSBDE at 800-821-3205.

_____ _____

Patient/Parent Signature Date

_____ _____

Office Representative Signature Date

Weatherford Pediatric Dental Associates, PLLC.

Patient Consent for the Disclosure of Information and Acknowledgement Form (HIPPA)

I understand that by signing this form I consent to the following:

1. Sharing information for the purpose of treatment:
   You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care and educational/wellness programs specified by my insurance plan. This will include communication with our team in verbal and non-verbal form such as postcard reminders, recognition boards, sign in information, and forms of communication for patient care and office visits.

2. Sharing information for purposes of payment:
   You will share all necessary information with my insurer(s), governmental entities, and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process companies, and in extreme situations, credit bureaus or collection agencies.

3. Sharing of information for the purposes of operations:
   You will share all information necessary for ongoing operations of this office, including (but not limited to) the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

I also understand that by signing this form, I give this office permission to leave messages on my answering machine or voicemail or with a relative regarding: notification of appointments, messages to call the office, test results, and any other information pertaining to your healthcare.

Information may be left with: _____ at my home or at another location. I understand that you will be unable to release ANY information to anyone other that the person/persons listed above.

My consent is freely given. I understand that I may revoke this consent at anytime if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

If you have any complaints you may contact the Texas State Board of Dental Examiners, (TSBDE), at 333 Guadalupe, Tower 3, Suite 800, Austin, TX 78701-3942 or you can call TSBDE at 800-821-3205.

_____ _____
Child or Children's Name(s) (PRINTED) DATE

_____ _____
Parent/Guardian Signature DATE

I have read and/or been offered/given a copy of the Notice of Privacy Practices for Weatherford Pediatric Dental Associates.

_____
Initials

_____ _____
OFFICE REPRESENTATIVE SIGNATURE DATE

Weatherford Pediatric Dental Associates

1508 Ft. Worth Hwy., Ste. 300
Weatherford, TX 76086
817-594-6364

RELEASE OF CONSENT FOR TREATMENT

Child or Children's Name(s):_____

Child or Childrens's Date of Birth: _____

I understand that by signing this form I consent to the following:

Notification by Dr. Westfall for changes in my child's treatment and information may be left with:

Name_____

Address_____

City_____ State_____ Zip_____

Phone number_____

Name_____

Address_____

City_____ State_____ Zip_____

Phone number_____

I understand that you will be unable to release ANY information to anyone other than the person/persons listed above. I authorize the Temporary Guardian, in the event that I cannot be contacted or if any urgency dictates, to act *in loco parentis* for the Child in respect of any circumstances, including any accident or illness, which may necessitate medical treatment, including surgery, and on my behalf to authorize any such treatment or surgery which they, in their sole discretion, (which discretion shall not be unreasonably exercised), may deem necessary. Medical treatment for the Child may also include dental surgery, x-ray, blood transfusion, anesthetic and medication provided any such medical treatment is performed by a duly licensed practitioner. I hereby accept full liability for all costs incurred through such medical treatment for the Child.

My consent is freely given. I understand that I may revoke this consent at anytime if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

Parent/Guardian Signature_____

Today's date_____

If more room is needed, please use bottom of this form.