Arizona Dental Medicine, P.L.L.C.
6596 N. Oracle Rd. Tucson, AZ 85704
(520) 297-9069
www.AZDentalMed.com

Patient Name _____

How did you first learn of our office _____

General Consent & Authorization

In filling out this registration, medical and dental health history, it is understood that the information provided by you is accurate and complete. It is also understood that this information will be held in the strictest of confidence. This office must be promptly informed of any changes in your health status (medical and dental). In addition to medical/dental radiographs, intraoral and/or extraoral photographs may be produced. This is to enhance the understanding of the medical/dental condition that may be present and/or for professional medical/dental/insurance consultation/education. No marketing distribution will be undertaken without receiving separate acknowledgment and consent. To ensure protection and enhance the understanding of our quality of service to our patients, conversations within this office may be recorded.

By your signature, the following is authorized and/or acknowledged as understood:

-You have been completely forthcoming and that you completely understand this treatment authorization.
-You will promptly inform this office of any changes in your health status (either medical or dental).
-The doctors of Arizona Dental Medicine and/or designated associate(s) and/or assistants may produce and distribute radiographs, photographs and/or other professionally related documents of you.

You understand and authorize the doctors of Arizona Dental Medicine and/or designated associate(s) and/or assistant(s) to perform, within the scope of their license, any and all procedures that are felt necessary in order to render a proper diagnosis and treatment recommendation. By consenting to examinations and/or recommended treatment, you authorize the doctors of Arizona Dental Medicine and/or designated associate(s) and/or assistant(s), within the scope of their license, to administer local anesthetics and to render treatment. If the patient is a minor (under the age of 18 in the State of Arizona), as the guardian you permit and authorize the doctors of Arizona Dental Medicine and/or designated associate(s) and/or assistant(s) to perform any and all dental techniques and procedures, within the scope of their license, whether or not you are present at the actual appointment when the treatment is rendered.

I authorize the release of information related to my condition as well as treatment received in this office to be verbally communicated to the following individuals other than myself:

_____ _____ _____

By signing below, my signature shall serve to establish authorization and consent (for the consent to diagnose and treat, and for the acknowledgement that I have read the Notice of Privacy Practices of the Health Insurance Portability & Accountability Act of 1996.).

Signature: _____

Parent or Guardian: _____