Dr. Dennis Hetland
3525 25th Street South - Fargo, ND 58104
701-298-9400

CONSENT FOR EVALUATION / ASSESSMENT / TREATMENT

I hereby authorize doctor or designated staff to perform Oral Examinations / Assessments, take radiographs, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of

_____'s dental needs

(patient's name)

I understand the doctor must perform a comprehensive evaluation to determine the health / disease status of my mouth. This involves a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures will be reported / charged separately.

A Comprehensive Oral Evaluation includes evaluation for oral cancer where indicated, the evaluation and recording of a patient's dental and medical history and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.

Additional diagnostic procedures that may be included to determine the status of my oral health may include, but are not limited to: Radiographs / Diagnostic Imaging (including interpretation); Additional tests and examinations; Oral Pathology Laboratory tests These are a part of my clinical record and the originals will be retained by my dentist. Copies will be provided should they be requested by another dental professional. There may or may not be a charge for additional copies.

Prescribed treatment may result from this Comprehensive Oral Evaluation. I understand that the purpose of the treatment is to correct my diseased oral tissues. The doctor has advised me that if conditions persist, without treatment my present condition will probably worsen in time, with potential risk to my overall oral health, as well as my overall general health.

I will be informed of possible alternative treatment, if any.

I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment I request and authorize. I will be given the opportunity to discuss my treatment plan and alternative treatments and to ask questions. All questions will be fully answered to my satisfaction. I understand that my failure to properly care for my oral health subsequent to any treatment may lead to failure of treatment.

I understand that a treatment plan is only an estimate and subject to modification depending on unforeseen and undiagnosable circumstances that may arise during the course of treatment.

I understand it is my responsibility to inform the doctor and/or appropriate staff members of any changes in my health status, or any changes in my medications. I have had the opportunity to discuss with the doctor my medical and health history, including any serious problems or injuries.

I understand that regardless of any dental benefits I may have, I am responsible for the payment of all dental fees and I agree to pay any attorney's fees, collection fees, court costs, or other costs that my be incurred to satisfy this obligation. I give consent to the doctors' or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to prove quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

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Signature of Patient / Parent / or Legal Guardian date

_____

Office Representative date