INFORMED CONSENT:

I authorize Dr. Jeppson or his associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effect, which may include, but not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventative procedures and basic dentistry, teeth may remain sensitive or even possibly painful during and/or after treatment. It may result in TMJ disorder.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, that may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or for the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs for the prevention of osteoporosis, such as FOSAMAX, BONIVA or ACTONE, may result in the complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I authorize the dentist to release any information including the diagnosis and the records of any treatment rendered to me during the period of such dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby do abide by the conditions outlined herein.

Patient/Guardian Signature _____ Date _____

Relationship to Patient _____

PRIVACY CONSENT:

I grant my permission to Dr. Jeppson or his assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have had a copy of this office's Privacy Policies offered to me. I acknowledge that a copy is always available at the office if such is ever needed. I agree to disclose to the dentist names of any individuals with whom I authorize Dr. Jeppson to discuss my dental care.

I certify that I have thoroughly read this form and have had any questions or concerns addressed. I hereby agree to abide by the conditions outlined herein.

Patient/Guardian Signature _____ Date _____

Relationship to Patient _____