PREHN DENTAL OFFICE
INFORMED CONSENT FOR TREATMENT, USE AND DISCLOSURE OF HEALTH INFORMATION

INITIAL DIAGNOSTIC PROCEDURES: In order to help formulate treatment recommendations, the following diagnostic procedures may be performed: (1) a medical and dental history, (2) discussion of your dental problems, concerns and desires, (3) x-rays, (4) plaster casts of the mouth and teeth, (5) examination of the mouth and associated structures, (6) photographs, and (7) conference with previous or concurrent treating health professionals. If additional diagnostic procedures or consultations are indicated, they will be discussed with you.

TREATMENT RECOMMENDATIONS: Are based on information gained from initial diagnostic procedures and previous experience and may vary for similar situations. The ultimate goal of treatment is to assist you in attaining optimum dental health and appearance. We will discuss with you the most appropriate and ideal treatment plan as well as reasonable alternative treatment plans. In those instances where supporting structures are compromised, recommendations can be made only after consultation with specialists. We will also inform you of the likely dental prognosis for each of these treatment plans and dental prognosis if no treatment is initiated at this time. You are welcome at any time to seek a second opinion.

REFERRAL TO OTHER SPECIALISTS: Dental restorative and prosthodontic treatment often requires concurrent treatment with other specialties such as: *Periodontics, Endodontics, Anesthesiology, Orthodontics, Oral Surgery, Physician (M.D.)*

ANESTHETICS: Most procedures are performed with a local anesthetic (commonly referred to as *Novocaine and Zylocaine*). In addition, sedative and pain medications can be used to help minimize anxiety and discomfort. In rare instances, allergic reactions may occur, so you are requested to inform our office staff of any known allergies you may have. Some sedative or pain medication may cause drowsiness. Therefore, when these medications are used, you would need to make arrangements for transportation with another person to and from the office. Nitrous Oxide Sedation (laughing gas) is used if needed as well.

DENTAL TREATMENT DURING PREGNANCY: Elective procedures or procedures that can be easily postponed should generally wait until after childbirth. Treatment of dental pain and urgent procedures can be performed with relative safety to the fetus by minimizing the use of medications and avoiding the use of nitrous oxide and other medications with known fetal effects. Therefore, it is essential that you inform Dr. Prehn of a confirmed or suspected pregnancy.

MEDICAL HISTORY: I understand the medical and dental history is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency. I will notify Dr. Prehn of any change in my health or medication prior to treatment.

TREATMENT: Upon such diagnosis, I authorize Dr. Prehn or the designated staff person to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care.

INFORMED CONSENT AND AUTHORIZATION: I certify that I have read and understand this *Informed Consent*, which outlines the general treatment considerations as well as the potential problems and complication of dental treatment. I understand that potential complications and problems may include, but are not limited to, those described in this document and discussed with me. I understand that during and following the treatment, and in the future, conditions may become apparent that warrant additional or alternative treatment pertinent to the success of comprehensive treatment. Recognizing the potential problems and risks of dental treatment, authorization is given for dental treatment to be rendered by the dentist and office staff. I also approve any modification in design, materials or care, if it is felt this is for my best interest. In addition, I consent that photographs and/or videos of the procedures may be shown for teaching and educational purposes. This consent is in force indefinitely unless revoked by me in writing.

CONTACTS: I also give my permission to have Prehn Dental Office personally contact me and remind me of needed appointments through the U.S. mail, (postcards or letters), e-mail, and/or voice messages at home or work.

PAYMENT: Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I authorize payment directly to Prehn Dental Office of any insurance benefits otherwise payable to me. I authorize the release of any information relating to dental claims.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment payment, activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:

Contact Person: Business Manager, 413 Jefferson St., Wausau, WI 54403
Telephone: 715-842-1270 Fax: 715-848-2906 E-mail: prehn@prehndental.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature: I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to use and disclose of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ **Date:**_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____