# Health History Form

**ADA** American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation:
Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact:
Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?
*Your Name* *Relationship*

**Do you have any of the following diseases or problems:** *(Check DK if you Don't Know the answer to the question)*

| | Yes | No | DK |
|---|---|---|---|
| Active Tuberculosis | ☐ | ☐ | ☐ |
| Persistent cough greater than a 3 week duration | ☐ | ☐ | ☐ |
| Cough that produces blood | ☐ | ☐ | ☐ |
| Been exposed to anyone with tuberculosis | ☐ | ☐ | ☐ |

***If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.***

## Dental Information *Please mark (X) your responses to the following questions.*

| | Yes | No | DK |
|---|---|---|---|
| Do your gums bleed when you brush or floss? | ☐ | ☐ | ☐ |
| Are your teeth sensitive to cold, hot, sweets or pressure? | ☐ | ☐ | ☐ |
| Is your mouth dry? | ☐ | ☐ | ☐ |
| Have you had any periodontal (gum) treatments? | ☐ | ☐ | ☐ |
| Have you ever had orthodontic (braces) treatment? | ☐ | ☐ | ☐ |
| Have you had any problems associated with previous dental treatment? | ☐ | ☐ | ☐ |
| Is your home water supply fluoridated? | ☐ | ☐ | ☐ |
| Do you drink bottled or filtered water? | ☐ | ☐ | ☐ |
| If yes, how often? *(Check one:)* DAILY☐ / WEEKLY ☐ / OCCASIONALLY ☐ | | | |
| Are you currently experiencing dental pain or discomfort? | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Do you have earaches or neck pains? | ☐ | ☐ | ☐ |
| Do you have any clicking, popping or discomfort in the jaw? | ☐ | ☐ | ☐ |
| Do you brux or grind your teeth? | ☐ | ☐ | ☐ |
| Do you have sores or ulcers in your mouth? | ☐ | ☐ | ☐ |
| Do you wear dentures or partials? | ☐ | ☐ | ☐ |
| Do you participate in active recreational activities? | ☐ | ☐ | ☐ |
| Have you ever had a serious injury to your head or mouth? | ☐ | ☐ | ☐ |

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

## Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| | Yes | No | DK |
|---|---|---|---|
| Are you now under the care of a physician? | ☐ | ☐ | ☐ |
| Are you in good health? | ☐ | ☐ | ☐ |
| Has there been any change in your general health within the past year? | ☐ | ☐ | ☐ |

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

If yes, what condition is being treated?

Date of last physical exam:

| | Yes | No | DK |
|---|---|---|---|
| Have you had a serious illness, operation or been hospitalized in the past 5 years? | ☐ | ☐ | ☐ |

If yes, what was the illness or problem?

| | Yes | No | DK |
|---|---|---|---|
| Are you taking or have you recently taken any prescription or over the counter medicine(s)? | ☐ | ☐ | ☐ |

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

# Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

*(Check DK if you Don't Know the answer to the question)*

| | Yes | No | DK |
|---|---|---|---|
| Do you wear contact lenses? | ☐ | ☐ | ☐ |
| **Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? | ☐ | ☐ | ☐ |
| Date: _____ If yes, have you had any complications? _____ | | | |
| Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? | ☐ | ☐ | ☐ |
| Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? | ☐ | ☐ | ☐ |
| Date Treatment began: _____ | | | |

| | Yes | No | DK |
|---|---|---|---|
| Do you use controlled substances (drugs)? | ☐ | ☐ | ☐ |
| Do you use tobacco (smoking, snuff, chew, bidis)? | ☐ | ☐ | ☐ |
| If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED | | | |
| Do you drink alcoholic beverages? | ☐ | ☐ | ☐ |
| If yes, how much alcohol did you drink in the last 24 hours? _____ | | | |
| If yes, how much do you typically drink in a week? _____ | | | |
| **WOMEN ONLY** Are you: | | | |
| Pregnant? | ☐ | ☐ | ☐ |
| Number of weeks: _____ | | | |
| Taking birth control pills or hormonal replacement? | ☐ | ☐ | ☐ |
| Nursing? | ☐ | ☐ | ☐ |

**Allergies.** Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

| | Yes | No | DK |
|---|---|---|---|
| Local anesthetics _____ | ☐ | ☐ | ☐ |
| Aspirin _____ | ☐ | ☐ | ☐ |
| Penicillin or other antibiotics _____ | ☐ | ☐ | ☐ |
| Barbiturates, sedatives, or sleeping pills _____ | ☐ | ☐ | ☐ |
| Sulfa drugs _____ | ☐ | ☐ | ☐ |
| Codeine or other narcotics _____ | ☐ | ☐ | ☐ |
| Metals _____ | ☐ | ☐ | ☐ |
| Latex (rubber) _____ | ☐ | ☐ | ☐ |
| Iodine _____ | ☐ | ☐ | ☐ |
| Hay fever/seasonal _____ | ☐ | ☐ | ☐ |
| Animals _____ | ☐ | ☐ | ☐ |
| Food _____ | ☐ | ☐ | ☐ |
| Other _____ | ☐ | ☐ | ☐ |

***Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.***

| | Yes | No | DK |
|---|---|---|---|
| Artificial (prosthetic) heart valve | ☐ | ☐ | ☐ |
| Previous infective endocarditis | ☐ | ☐ | ☐ |
| Damaged valves in transplanted heart | ☐ | ☐ | ☐ |
| Congenital heart disease (CHD) | | | |
| Unrepaired, cyanotic CHD | ☐ | ☐ | ☐ |
| Repaired (completely) in last 6 months | ☐ | ☐ | ☐ |
| Repaired CHD with residual defects | ☐ | ☐ | ☐ |

*Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

| | Yes | No | DK |
|---|---|---|---|
| Cardiovascular disease | ☐ | ☐ | ☐ |
| Angina | ☐ | ☐ | ☐ |
| Arteriosclerosis | ☐ | ☐ | ☐ |
| Congestive heart failure | ☐ | ☐ | ☐ |
| Damaged heart valves | ☐ | ☐ | ☐ |
| Heart attack | ☐ | ☐ | ☐ |
| Heart murmur | ☐ | ☐ | ☐ |
| Low blood pressure | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ |
| Other congenital heart defects | ☐ | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ | ☐ |
| Rheumatic heart disease | ☐ | ☐ | ☐ |
| Abnormal bleeding | ☐ | ☐ | ☐ |
| Anemia | ☐ | ☐ | ☐ |
| Blood transfusion | ☐ | ☐ | ☐ |
| If yes, date: _____ | | | |
| Hemophilia | ☐ | ☐ | ☐ |
| AIDS or HIV infection | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ |
| Autoimmune disease | ☐ | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ | ☐ |
| Systemic lupus erythematosus | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| Sinus trouble | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ |
| Cancer/Chemotherapy/ Radiation Treatment | ☐ | ☐ | ☐ |
| Chest pain upon exertion | ☐ | ☐ | ☐ |
| Chronic pain | ☐ | ☐ | ☐ |
| Diabetes Type I or II | ☐ | ☐ | ☐ |
| Eating disorder | ☐ | ☐ | ☐ |
| Malnutrition | ☐ | ☐ | ☐ |
| Gastrointestinal disease | ☐ | ☐ | ☐ |
| G.E. Reflux/persistent heartburn | ☐ | ☐ | ☐ |
| Ulcers | ☐ | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ |
| Hepatitis, jaundice or liver disease | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ |
| Fainting spells or seizures | ☐ | ☐ | ☐ |
| Neurological disorders | ☐ | ☐ | ☐ |
| If yes, specify: _____ | | | |
| Sleep disorder | ☐ | ☐ | ☐ |
| Do you snore? | ☐ | ☐ | ☐ |
| Mental health disorders | ☐ | ☐ | ☐ |
| Specify: _____ | | | |
| Recurrent Infections | ☐ | ☐ | ☐ |
| Type of infection: _____ | | | |
| Kidney problems | ☐ | ☐ | ☐ |
| Night sweats | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ |
| Persistent swollen glands in neck | ☐ | ☐ | ☐ |
| Severe headaches/ migraines | ☐ | ☐ | ☐ |
| Severe or rapid weight loss | ☐ | ☐ | ☐ |
| Sexually transmitted disease | ☐ | ☐ | ☐ |
| Excessive urination | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? | ☐ | ☐ | ☐ |

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

| | Yes | No | DK |
|---|---|---|---|
| Do you have any disease, condition, or problem not listed above that you think I should know about? | ☐ | ☐ | ☐ |

Please explain:

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

**FOR COMPLETION BY DENTIST**

Comments:

# HIPAA – PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES

## *HIPAA – CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD Y CONFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

I acknowledge that I have been provided with **A PLUS DENTIST, LLC.,** "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

**Confirmo que se me ha proveído con la "Nota De Practicas De Privacidad" de* **A PLUS DENTIST, LLC.,** *y doy mi consentimiento para usar y compartir Información Personal De Salud como lo permita y/o requiera la ley.*

**Patient Name:** *(please print)* _____

**Nombre Del Paciente: (nombre en letra de molde por favor)*

**Patient Signature** *(or legal representative; proof may be requested)* _____

**Firma Del Paciente: (o representante legal; prueba puede ser requerida)*

**Date:** _____

**Fecha:*

## EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM
## *CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJES DE TEXTO A MOVIL

**Purpose:** This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **A PLUS DENTIST, LLC., (APD)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **APD** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **APD** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **APD** and I, and consent to the conditions outlined herein. Any questions I may have had were answered.

***Propósito:** Esta forma es usada como consentimiento de usted para comunicarnos vía correo electrónico/mensaje de texto a móvil en referencia a su Información de Salud Protegida. **A PLUS DENTIST, LLC., (APD)** ofrece a sus pacientes la oportunidad de comunicación vía correo electrónico/mensaje de texto a móvil. Trasmitir información vía correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. **APD** usara formas razonables de proteger confidencial y seguro la información mandada a usted vía correo electrónico/mensaje de texto a móvil. De todas formas, **APD** no podrá garantizarle proteger confidencial y seguro la comunicación vía correo electrónico/mensaje de texto a móvil y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía correo electrónico/mensaje de texto a móvil entre **APD** y yo, y consiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me a sido respondida.

### Patient Acknowledgment & Agreement / *Reconocimiento y Acuerdo del Paciente

**My Consented Email Address Is:** _____

**Mi Correo Electrónico Consentido Es:*

**My Consented Mobile Number For Text Messaging is:** _____

**Mi Numero Móvil Para Mensaje De Texto Consentido Es:*

**Patient Signature:** _____ **Date:** _____

**Firma del Paciente* ****Fecha***

**IN CASE OF EMERGENCY:** *Please call 911 or proceed to the nearest emergency room.* ***Do not use this way of communication for that purpose.***
****EN CASO DE EMERGENCIA:** Por favor llame al 911 or proceda al centro de emergencia mas cercano.* ***No use esta forma de comunicación para este propósito.***

Rev.09/19

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

## PATIENT INFORMATION

**Patient Name:** | **Date of Birth:**

**Social Security No:** | **Telephone No:**

**Address:**

## RELEASE TO

I authorize **A PLUS DENTIST, LLC;** to release the health information indicated below to:
**And** for the purpose of alternative means of confidential communication the use of the following Email Address:

**Person/Organization Name:**

**Address:**

**Telephone No:** | **Email Address:**

**Dates of Medical Record Release:**

**A PLUS DENTIST, LLC., (APD)** offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. **APD** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **APD** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and I consent to the conditions outlined herein. Any questions I may have had were answered.

## REASON FOR DISCLOSURE

☐ **Continuing Care** ☐ **Legal** ☐ **Other Purpose** *(please specify)*

☐ **Insurance** ☐ **Personal Use**

## INFORMATION TO BE RELEASED

☐ **Complete Medical Record** ☐ **Operative Reports**

☐ **Lab Reports** ☐ **Pathology *Reports***

☐ **Radiology Reports** ☐

☐ ☐

☐ **Other** *(please specify)*

## SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ **Drug/Alcohol Abuse or Treatment** ☐ **Genetic Testing Information**

☐ **HIV/AIDS, Sexually Transmitted Disease (STD) Test Results or Diagnoses** ☐ **Mental Health Treatment or Psychotherapy Notes**
*(The release of Psychotherapy Notes require a separate authorization)*

This consent is subject to revocation at any time except to the extent the action has been taken thereon. ***This authorization and consent will expire one year from the date of authorization written below.*** Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the recipient may no longer be protected by law.

**Patient Signature:** *(Guardian/Legal Representative)* | **Date Signed:**

**Print Name:** *(Please Print)* | **Relationship If Other Than Patient:**

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care).*

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FROM OTHER HEALTHCARE FACILITIES

## PATIENT INFORMATION

**Patient Name:** | **Date of Birth:**

**Social Security No:** | **Telephone No:**

**Address:**

## REQUEST TO

**Name of Healthcare Facility from which Records are Requested:**

**Telephone No.:** | **Fax No.:**

**Address:**

**Dates of Treatment Requested:** | **Reason For Disclosure:**

I hereby authorize **A PLUS DENTIST, LLC; to obtain** the health information indicated below ***AND*** for the purpose of alternative means of confidential communication the use of their email address. **APD** offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. **APD** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **APD** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and consent to the conditions outlined herein. Any questions I may have had were answered.

**Mail Information To:** **A PLUS DENTIST, LLC** | **Address: 14277 SW 42 ST MIAMI, FL 33155**

**Or Fax To:** **786.703.6194** | **Email: Adentist14277@gmail.com**

## INFORMATION TO BE RELEASED

- ☐ **Complete Medical Record**
- ☐ **Operative Reports**
- ☐ **Radiology Reports**
- ☐ **Pathology Reports**
- ☐ **Lab Reports**
- ☐
- ☐
- ☐
- ☐ **Other** *(please specify)*

## SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:

- ☐ **Drug/Alcohol Abuse or Treatment**
- ☐ **Genetic Testing Information**
- ☐ **HIV/AIDS, Sexually Transmitted Disease (STD) Test Results or Diagnoses**
- ☐ **Mental Health Treatment or Psychotherapy Notes**
  *(The release of Psychotherapy Notes require a separate authorization)*

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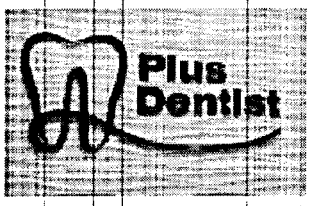
**Patient Signature:** | **Date Signed:**
*(Guardian/Legal Representative)*

**Print Name:** | **Relationship If Other Than Patient:**
*(Please Print)*

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18. **For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.*




14277 SW 42ND STREET
MIAMI, FL 33175
305-222-9219 PHONE
305-222-9119 FAX

## CONSENT FORM FOR DENTAL TREATMENT

Please read and initial each of the following paragraphs, read and sign the section at the bottom of this form Name of patient

TREATMENT TO BE DONE: I understand that I will have the following treatment:

Fillings____ Bridges_____ Crowns _____ Extractions_____ Root Canal_____

Other_____ Initials_____

DRUGS AND MEDICATIONS: I understand that antibiotics, pain relievers, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Initials_____

CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures due to conditions found while treating my teeth that were not found during examination, the most common being root canal therapy, followed by routine restorative procedures. I give my permission to the Dentist to make any/all necessary changes and additions. Initials _____

TOOTH EXTRACTION: The alternatives to a tooth extraction (root canal therapy, crowns, and periodontal surgery, etc.) have been explained to me and I authorize the Dentist to extract the following teeth_____ and any other(s) that are necessary for reasons described in paragraph #3. I understand that tooth extraction does not always remove all infection, if any, additional treatment may be needed. I understand the risks of tooth extraction, some of which are pain, swelling, spread of infection, indefinite socket (days to months), or fractured jaw. I understand that I may need further treatment by a specialist or even be hospitalized if complications arise during or after treatment, and it is my responsibility. Initials

_____

CROWNS, BRIDGES AND CAPS: I understand that sometimes it is not possible to exactly match the color of natural teeth. I further understand that I may be bringing temporary crowns that can easily fall out and that I must take care to ensure they do not fall out until the permanent crowns are delivered. I am aware that the last opportunity to make changes to my new crown, bridge, or cap (including changes in shape, fit, size, and color) will be prior to cementation. Initials _____

FULL OR PARTIAL DENTURES: I am aware that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. Problems that can arise from wearing these braces have been explained to me, including loosening, pain, and possible rupture. I understand that the last opportunity to make changes to my new dentures (including changes in fit, size, and color) will be when I attend my "teeth-in-wax" try-in consultation. I understand that most dentures require another alignment approximately three to twelve months after placement. Initial placement. The cost of this procedure is not included in the initial cost of the dentures. Initials_____

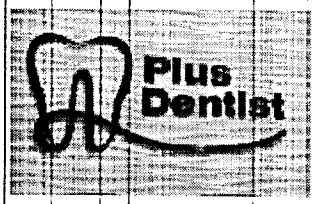
ENDODONTIC (ROOT CANAL) TREATMENT: I understand that there is no guarantee that root canal treatment will save my tooth, and that complications from treatment may occur, and that metal objects are sometimes cemented into the tooth or extended into the tooth, through the root canal, which does not necessarily affect the success of the root canal treatment (apicoectomy). Initials_____

PERIODONTAL (TISSUE AND BONE) LOSS: I understand that I have a serious condition, which is causing inflammation or loss of gums and bone, and that can cause the loss of my teeth. Alternative treatment plans, including gum surgery, replacement and/or extractions, have been explained to me. I understand that undergoing any dental procedure may have a future negative effect on my periodontal condition. Initials_____

I understand that dentistry is not an exact science and that, therefore, accredited practitioners cannot guarantee results for complete. I acknowledge that no one has guaranteed or assured me anything regarding the dental treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. I am satisfied that the questions have been answered, I give my consent for the proposed treatment to be carried out.

Date: _____

Patient's signature: _____




14277 SW 42ND STREET
MIAMI, FL 33175
305-222-9219 PHONE
305-222-9119 FAX

**PHOTO VIDEO CONSENT**

I, _____ authorize A Plus Dentist, Dr Yannelys Martin, and staff to take pictures and videos of my face, mandible, and teeth.

I understand that the photographs and videos will be used for my dental care.

**PERMISO PARA TOMAR FOTOGRAFIAS Y VIDEOS**

Yo, _____ autorizo por medio de este documento, a A Plus Dentist, Dra Yannelys Martin y su personal para tomar fotografias y videos de mi cara, mandibula, y dientes.

Entiendo que estas fotografias y videos seran utilizados como un registro de mi cuidado dental.

Patient Signature: _____

Dr Signature: _____

Date: _____