ACQUAINTANCE FORMS

CONSENT TO TREATMENT:

I hereby authorize Dr. Sletten and staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental health at the initial appointment.

Upon diagnosis, I authorize the Dr. Sletten and staff to perform all recommended and mutually agreed upon treatment and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medications as necessary. I understand that using anesthetic agents poses certain risk, such as temporary or permanent paresthesia. I understand that I can ask for complete explanation of any possible risks.

AUTHORIZATION OF USE OF PERSONAL INFORMATION:

I give consent to Dr. Sletten's or designated staff's use and disclosure of any oral, written or electronic health record that is individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimal amount of information needed to provide quality care will be used or disclosed.
I have read and understand the HIPPA information provided.

Signature_____Date_____