CONSENT FORM

Last Name _____ First Name _____

Date of Birth _____

REGARDING MY MEDICAL HISTORY:

_____ (Initials) I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify Dr. Charles Wade, his associates, or staff of any changes at any subsequent appointment.

REGARDING GENERAL CONSENT TO DENTAL PROCEDURES:

_____ (Initials) I do hereby authorize and request the performance of dental services by Dr. Charles Wade and such associates or employees he may designate, and the use of whatever procedures Dr. Wade and associates may deem necessary or advisable to maintain my dental health, or the dental health of any minor or other individual for which I am responsible for treatment. Any surgery, extractions, or gum therapy will require my additional consent to treatment. For any restorative treatment such as fillings, crowns, and tooth replacement prosthesis, I authorize Dr. Charles Wade or associates to perform.

REGARDING ANESTHESIA:

_____ (Initials) I authorize for myself, and any minor or other individual for which I have responsibility, the administration of any anesthetics, analgesics or sedative, including without limitation, nitrous oxide, therapeutic and/or other pharmaceutical agents (including those related to restorative, palliative, therapeutic, or surgical treatment) that may be deemed appropriate by Dr. Charles Wade and associates. I understand that anesthetics may be therapeutic, diagnostic, or for treatment of facial pain. I understand that antibiotics, anesthetics, analgesics and other medications may cause swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I understand that additional complications may include, but are not limited to: pain, swelling, bruising, temporary limited opening, hematoma, cardiac stimulations, muscle soreness, temporary or permanent numbness, and local infections. I understand that in occasional cases, the anesthesia may be prolonged and in very rare cases, permanent.

REGARDING DENTAL TREATMENT:

_____ (Initials) I understand that any treatment plans presented, along with fees outlined, could change depending on the time elapsed since the initial examination and the extent of dental pathology. I understand that once the treatment plan has begun, complications may arise that dictate additional procedures or treatment. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I authorize Dr. Charles Wade and associates to make any/all changes and additions as necessary.

_____ (Initials) I understand that a more extensive restoration than originally planned, including but not limited to root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I

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realized that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns.

_____ (Initials) I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I will receive.

REGARDING OFFICE POLICIES:

_____ (Initials) I hereby agree to show up for my scheduled appointments on time and to give a 48-hour advance notice if I need to cancel or reschedule an appointment. I understand that a $50 fee may be assessed to my account without at least 48 hours advance notice of cancellation. I also understand that all cancellation fees must be paid prior to scheduling another appointment. A broken appointment is a loss to three people – the patient who missed the valuable time, the patient who could have taken the valuable time, and the doctor who was fully staffed and prepared for the appointment.

_____ (Initials) I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation. I agree that if my credit card or debit card charge is placed in dispute for any reasons whatsoever, I will pay Charles F. Wade, D.M.D., P.A. a collection processing fee of $30 in addition to the original charges due on this transaction.

_____ (Initials) I give Charles F. Wade, DMD., P.A. and associates the absolute right and permission to use my audio/visual materials, including photographs/slides or written communications for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said materials.

CONSENT: I have had the opportunity to have all my questions answered by Dr. Charles F. Wade and associates or staff, and I certify that I understand English.

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Printed Guardian Name (if applicable) **Relationship to Patient**