DOWNTOWN DENTAL
RICHARD M. RATHKE JR., D.D.S.
GENERAL DENTISTRY

PATIENT INFORMATION

Patient's Name _____ Date of Birth _____

SS# _____ State Id / Driver's Lic # _____ What State _____

Email Address _____

Home Address _____ Apt/Suite # _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____ Employer _____

Address _____ City _____ State _____ Zip _____

Emergency Contact Name _____ Phone # _____

How did you hear about our office? _____

Were you referred by a patient? _____ If yes, who can we thank? _____

IF PATIENT IS A MINOR PLEASE FILL OUT

If Minor Guarantor's Name _____ SS# _____

Guarantor's Phone # _____ Guarantor's Email _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Relationship to Patient _____

Insured's Phone # _____ Insured's DOB _____ Insured's SS# _____

Insured's Address _____

Dental Insurance Company _____ Group # _____

Dental Insurance Phone # _____ Member ID # _____

307 Tchoupitoulas Street Ste. #200 New Orleans, Louisiana 70130 P: (504) 528-7800 F: (504) 528-7801
WWW.DowntownDentalNewOrleans.com | Info@DowntownDentalNewOrleans.com

MEDICAL HISTORY

Are you under a physician's care now? Why? Who? _____ Phone _____ Yes No

Have you ever been hospitalized or had a major operation? Discuss _____ Yes No

Have you ever had a serious injury to your head or neck? Discuss _____ Yes No

Are you taking any medications, pills or drugs? What? _____ Yes No

Are you allergic to any medications or substances? Please check box below

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss Yes No

* If yes to any of the starred conditions, please call prior to your appointment...Premedication may be required

	Yes	No
Heart Trouble/Disease	☐	☐
Heart Murmur*	☐	☐
Irregular Heart Beat	☐	☐
Angina/Chest Pain	☐	☐
Heart Attack/Failure	☐	☐
Congenital Heart Disorder	☐	☐
Mitral Valve Prolapse*	☐	☐
Scarlet Fever	☐	☐
Rheumatic Fever*	☐	☐
Artificial Heart Valve*	☐	☐
Heart Pace Maker	☐	☐
Heart Surgery*	☐	☐
High Blood Pressure	☐	☐
Blood Disease	☐	☐
Bruise Easily	☐	☐
Anemia	☐	☐
Excessive Bleeding	☐	☐
Sickle Cell Anemia	☐	☐

	Yes	No
Hemophillia (bleeding problem)	☐	☐
Recent Blood Transfusion	☐	☐
Swelling of Limbs	☐	☐
Lung Disease	☐	☐
Breathing Problem	☐	☐
Shortness of Breath	☐	☐
Frequent Cough	☐	☐
Hay Fever	☐	☐
Sinus Trouble	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Cancer	☐	☐
X-Ray Treatments (Radiation)	☐	☐
Chemotherapy	☐	☐
Stomach/Intestinal Disease	☐	☐
Ulcers	☐	☐
Recent Weight Loss	☐	☐

	Yes	No
Diabetes	☐	☐
Excessive Thirst	☐	☐
Hypoglycemia	☐	☐
Liver Disease	☐	☐
Hepatitis A (Infectious)	☐	☐
Hepatitis B or C	☐	☐
Yellow Jaundice	☐	☐
Kidney Problems	☐	☐
Renal Dialysis	☐	☐
Thyroid Disease	☐	☐
Arthritis/Gout	☐	☐
Rheumatism	☐	☐
Pain in Jaw Joint	☐	☐
Cortisone/Steroid Therapy	☐	☐
Artificial Joint*	☐	☐
Organ Transplant*	☐	☐

	Yes	No
AIDS	☐	☐
HIV Positive	☐	☐
Drug Addiction	☐	☐
Cold Sores	☐	☐
Fever Blisters	☐	☐
Herpes	☐	☐
Stroke	☐	☐
Convulsions	☐	☐
Epilepsy or Seizures	☐	☐
Fainting or Dizziness	☐	☐
Glaucoma	☐	☐
Tumors or Growths	☐	☐
Nervousness	☐	☐
Psychiatric Care	☐	☐
Alzheimer's Disease	☐	☐
Allergies (Pollen/Dust)	☐	☐
Hives or Rash	☐	☐

Have you ever had any illness not checked above? Yes ____ No ____ Discuss _____

Do you smoke? Yes ____ No ____ How many packs / day? _____

Do you use any other form of tobacco? Yes ____ No ____ What kind? _____

Number of sodas or sweet drinks per day? _____

Do you wish to talk to the dentist privately about any problems? Yes ____ No ____ Discuss _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

Patient Signature

Reviewed by Doctor _____ Date _____ BP _____

DENTAL HISTORY

Are any family members current patients? Yes No

Name of previous dentist _____

Date of last dental visit _____

How long since last cleaning? _____

Reason for changing _____

Describe your current dental problem _____

_____

APPREHENSION

Do you experience fear of having dental treatment performed? Yes No

Anything specific? _____

Do you dread the numbing after effects? Yes No

Have you had any unpleasant dental experiences? Yes No

Have you ever received laughing gas in a dental office? Yes No

Have you ever received any other kind of sedation for treatment? Yes No

Do you feel you need any help overcoming fear? Yes No

TEETH PROBLEMS

Are your teeth sensitive to hot, cold, sweets or pressure? Yes No

Does food regularly wedge between certain teeth? Yes No

Do you have any areas that are hard to floss? Yes No

YOUR SMILE

Do you think you have a pretty smile? Yes No

Are your teeth crooked? Yes No If so, does this bother you? Yes No

_____

Have you had any cosmetic dentistry? Yes No

Do you have any fillings or blemishes on your teeth that look bad? Yes No

Would you like to have whiter teeth? Yes No

Is there anything that you feel could make your smile look better?

_____

_____

HEADACHES AND FACIAL PAIN

Do you have frequent headaches? Yes No

Do you experience popping or clicking upon opening or closing? Yes No

Do your jaw or facial muscles ever get tired or sore after chewing, sleeping, stress, etc? Yes No

Do you experience facial muscle pain while chewing or when you wake up? Yes No

GUM PROBLEMS

Do your gums ever bleed when you brush or floss: Yes No

Have your gums receded or pulled away from your teeth? Yes No

Do you have bad breath or bad tastes? Yes No

DOWNTOWN DENTAL
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FINANCIAL POLICIES

Dental Insurance

As a courtesy to you, we will be happy to file your insurance. Your insurance policy is a contract between you and your insurance company. We will attempt to estimate your portion (co-payment) but please remember that this is only an estimate and the actual amount will vary depending on your deductible met and whether your insurer accepts our fees as "usual and customary (UCR)." It is the patient's responsibility for any unpaid balances regardless of your insurance coverage.

Financial Agreement

Payment is due at the time services are rendered. The patient (guardian) agrees to be fully responsible for total payment of treatment performed in the office, including treatment not covered by dental insurance. You will have **30 days** to pay any remaining balance. If your account is not paid in the allocated time, it will be turned over to our accountant and subject to a **$25.00** delinquent billing fee. If an account is overdue by **90** days, you may be forwarded over to a collection agency and will be responsible for your balance as well as any other billing or legal fees.

NSF Fee

There will be a **$35.00** NSF fee for all returned checks.

Broken Appointment

Please remember that once you have scheduled an appointment, this time has been reserved especially for you. We are dedicated to your quality care and are pleased to reserve this time for your treatment. As a courtesy, we will attempt to remind you of your reservation by calling, texting or emailing the number you have provided. However, it is the patient's responsibility to keep the appointment even if we are unable to contact you. Should a change be necessary, we require a minimum of **24** hours notification. Without proper notice, a **$50.00** broken appointment fee for hygiene and a **$125.00** broken appointment fee for doctor treatment will be applied to your account. We thank you for your cooperation.

I certify that I have read, understand and accept this agreement.

_____ _____

(Patient/Guardian Signature) **(Date)**

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

About This Notice

This notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to maintain the privacy of your protected health information; give you this notice of our legal duties and privacy practices with respect to your protected health information; and follow the terms of our notice that are currently in effect. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at the time as well as any information we receive in the future. You can obtain any revised Notice of Privacy Practices by contacting our office.

How We May Use and Disclose Your Protected Health Information

The following examples describe different ways that we may use and disclose your protected health information. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office. We are permitted to use and disclose your protected health information for the following purposes. However, our office may never have reason to make some of these disclosures.

For Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care treatment and any related services. We may also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

For Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to your health plan to obtain approval for hospital admission.

For Health Care Operations
We may use and disclose your protected health information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may use your protected health information to review the treatment and services you receive to check on the performance of our staff in caring for you. We also may disclose information to doctors, nurses, technicians, medical students, and other personnel for educational and learning purposes. The entities and individuals covered by this notice also may share information with each other for purposes of our joint health care operations.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services
We may use and disclose your protected health information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Fundraising Activities
We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our office and request that these fundraising materials not be sent to you.

Plan Sponsors
If your coverage is through an employer sponsored group health plan, we may share protected health information with your plan sponsor.

Facility Directories
Unless you object, we may use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people

that ask for you by name. Members of the clergy will be told your religious affiliation. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare
Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Required by Law
We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health
We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Business Associates
We may disclose your protected health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Communicable Diseases
We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight
We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect
We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration
We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.

Legal Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement
We may also disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation
We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research
We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity
Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security
When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation
Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates
We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

For Data Breach Notification Purposes
We may use or disclose your protected health information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan. if applicable, through which you receive coverage.

Required Uses and Disclosures
Under the law, we must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization.

Additionally, if a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.

Your Rights Regarding Health Information About You

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your protected health information that is contained in your designated file for as long as we maintain the protected health information. A "designated file" contains medical and billing records and any other records that your physician and the office uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You must make a written request to inspect and copy your designated file. We may charge a reasonable fee for any copies.

Additionally, if we maintain an electronic health record of your designated file, you have the right to request that we send a copy of your protected health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your protected health information.

Depending on the circumstances, we may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact our office if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

This office is not required to agree to a restriction that you may request. If this office believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If this office does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our office.

You have the right to restrict information given to your third party payer if you fully pay for the services out of your pocket. If you pay in full for services out of your own pocket, you can request that the information regarding the services not be disclosed to your third party payer since no claim is being made against the third party payer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our office.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in your designated file for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our office if you have questions about amending your medical record. Your request must be in writing and provide the reasons for the requested amendment.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

You have the right to receive notice of a security breach. We are required to notify you if your protected health information has been breached. The notification will occur by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your protected health information. The notification requirements under this section only apply if the breach poses a significant risk for financial, reputational, or other harm to you. The notice will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

Not every impermissible use or disclosure of protected health information constitutes a reportable breach. The determination of whether an impermissible breach is reportable hinges on whether there is a significant risk of harm to you as a result of impermissible activity. For example, if your protected health information was inappropriately shared with a billing clerk and she understood her confidentiality obligations, you would not need to be notified of the breach. If we inadvertently disclosed that you received services at our facility, without more specifics, this also may not be a reportable breach because it may not have been a significant risk of financial or reputational harm. The key to determining potential harm is whether sufficient information was released that would allow identity theft or harm you because of the likelihood of sharing sensitive health data.

Complaints or Questions

You may complain to us or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a written complaint with us by notifying our office of your complaint. We will not retaliate against you for filing a complaint. You may reach our office by calling: ( ) _____ .
Telephone

If you have a question about this privacy notice, please contact our Privacy Officer at: ( ) _____ .
Telephone

Effective Date: This notice is effective as of 1/1/2011.

DOWNTOWN DENTAL
RICHARD M. RATHKE JR., D.D.S.
GENERAL DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's notice of privacy practices.

_____
(SIGNATURE - Patient/Guardian)

_____
(PRINT NAME – Patient/Guardian)

_____
(IF GUARDIAN, Relationship to patient)

_____
(Date)

Below is for office use only:

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because (initial by response):

- Individual refused to sign. _____
- Communication barriers prohibited obtaining the acknowledgement. _____
- An emergency situation prevented us from obtaining acknowledgement. _____
- Other (please specify): _____

_____
_____
_____

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RICHARD M. RATHKE JR., D.D.S.
GENERAL DENTISTRY

CONSENT FORM FOR GENERAL PROCEDURES

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

Further, I understand that I am entering into a contractual relationship with Dr. Richard Rathke, DDS, for professional care. I further understand that meritless and frivolous claims for dental malpractice have an adverse effect upon the cost and availability of dental care, and may result in irreparable harm to a dental provider. As additional consideration for professional care provided to me by Dr. Richard Rathke, DDS, I agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against Dr. Richard Rathke, DDS.

Furthermore, should a dental malpractice case or cause of action be initiated or pursued, I agree to use expert witness(es) who practice primarily in the same specialty as Dr. Richard Rathke, DDS. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Dental Association. In further consideration for this, Dr. Richard Rathke, DDS, agrees to the same stipulations.

I acknowledge that monetary damages may not provide an adequate remedy for breach of this agreement. Such breach may result in irreparable harm to doctor's reputation and business. Both Dr. Richard Rathke, DDS, and I agree in the event of a breach to allow specific performance and/or injunctive relief.

As with all healthcare treatment, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly knows risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling and discomfort after treatment.

2. Infection in need of medication, follow-up procedures or other treatment.

3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste.

4. Damage to adjacent teeth, restorations or gums.

5. Possible deterioration of your condition which may result in tooth loss.

6. The need for replacement of restorations, implants or other appliances in the future.

7. An altered bite in need of adjustment.

8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.

9. A root tip, bone fragment or a piece of a dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop.

10. Jaw fracture.

11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.

12. Allergic reaction to anesthetic or medication.

13. Need for follow-up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

_____ _____

(Signature-Patient/Guardian) (Date)

_____ _____

(PRINT NAME – Patient/Guardian) (Witness)

_____

(IF GUARDIAN, Relationship to patient)