Patient Information Sheet

DATE
CHART #

PATIENT INFORMATION

FIRST NAME	MI	LAST NAME	DOB	SEX ☐M ☐F

SSN	DRIVER'S LICENSE/ID #	ST	HOME PHONE	CELL PHONE	WORK PHONE

E-MAIL	COMMUNICATION PREFERENCE FOR CLINICAL INFO (SELECT ONE) ☐ HOME PHONE ☐ CELL PHONE ☐ WORK PHONE ☐ E-MAIL ☐ MAIL	PREFERRED LANGUAGE ☐ DECLINED TO SPECIFY

RACE (PLEASE SELECT UP TO TWO APPLICABLE CHOICES) ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE ☐ OTHER RACE ☐ DECLINE TO SPECIFY	ETHNICITY ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ DECLINE TO SPECIFY

ZIP	HOME ADDRESS	CITY	ST

EMPLOYER	POSITION	HOW LONG?

EMPLOYER ADDRESS	CITY	ST	ZIP

MEDICAL INSURANCE CARRIER	PREFERRED PHARMACY	ADDRESS	CITY	ST	ZIP

RESPONSIBLE PARTY (DISREGARD IF SAME AS ABOVE)

FIRST NAME	MI	LAST NAME	DOB	SEX ☐M ☐F	RELATIONSHIP TO PATIENT

SSN	DRIVER'S LICENSE/ID #	ST	HOME PHONE	CELL PHONE	WORK PHONE	E-MAIL

ZIP	HOME ADDRESS	CITY	ST

EMPLOYER	POSITION	HOW LONG?

EMPLOYER ADDRESS	CITY	ST	ZIP

PREFERRED PHARMACY	PHONE

EMERGENCY CONTACTS

CONTACT #1 FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	E-MAIL

HOME ADDRESS	CITY	ST	ZIP	HOME PHONE	CELL PHONE	WORK PHONE

CONTACT #2 FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	E-MAIL

HOME ADDRESS	CITY	ST	ZIP	HOME PHONE	CELL PHONE	WORK PHONE

PRIMARY INSURANCE

☐ INSURANCE CARD PROVIDED

INSURED'S FIRST NAME	LAST NAME

DOB	SEX ☐M ☐F	PATIENT'S RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ PARENT

HOME ADDRESS

CITY	ST	ZIP	INSURED'S SSN

EMPLOYER	EMPLOYER'S PHONE NUMBER

INSURANCE COMPANY	INSURANCE COMPANY'S PHONE NUMBER

GROUP #	POLICY #

POLICY EFFECTIVE DATE	UNION NAME AND LOCAL UNION NUMBER

SECONDARY INSURANCE

☐ INSURANCE CARD PROVIDED

INSURED'S FIRST NAME	LAST NAME

DOB	SEX ☐M ☐F	PATIENT'S RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ PARENT

HOME ADDRESS

CITY	ST	ZIP	INSURED'S SSN

EMPLOYER	EMPLOYER'S PHONE NUMBER

INSURANCE COMPANY	INSURANCE COMPANY'S PHONE NUMBER

GROUP #	POLICY #

POLICY EFFECTIVE DATE	UNION NAME AND LOCAL UNION NUMBER

INITIALS OF PATIENT	INITIALS OF RESPONSIBLE PARTY

HEALTH HISTORY

Patient First Name | MI | Last Name | Birthdate | Sex ☐ Male ☐ Female

GENERAL HEALTH QUESTIONS

1. Have you had any serious illness, operations or hospitalizations? ☐ Yes ☐ No

2. Are you under a physician's care at this time? ☐ Yes ☐ No
   Name, address and phone # of physician:

Do you have or did you ever have any of the following?

Cardiovascular Health

3. High blood pressure ☐ Yes ☐ No
4. Angina or heart attack ☐ Yes ☐ No
5. Chest pain on physical exertion ☐ Yes ☐ No
6. Coronary artery blockage or treatment (bypass, stent, etc.) ☐ Yes ☐ No
7. Heart valve problem or replacement ☐ Yes ☐ No
8. Heart murmur ☐ Yes ☐ No
9. Heart disease, problem or treatment ☐ Yes ☐ No
10. Rheumatic fever ☐ Yes ☐ No
11. Past use of Fen-Phen ☐ Yes ☐ No
12. Irregular heart beat or pacemaker ☐ Yes ☐ No
13. Difficulty breathing when lying down ☐ Yes ☐ No
14. Stroke ☐ Yes ☐ No
15. Low blood pressure ☐ Yes ☐ No

Respiratory Health

16. Asthma ☐ Yes ☐ No
17. Emphysema or respiratory problems ☐ Yes ☐ No
18. Chronic sinus problems ☐ Yes ☐ No
19. Tuberculosis or persistent cough ☐ Yes ☐ No

Endocrine/Blood/Immune Health

20. Diabetes ☐ Yes ☐ No
21. Frequent thirst or frequent urination ☐ Yes ☐ No
22. Thyroid problems ☐ Yes ☐ No
23. Abnormal bleeding, bruise easily ☐ Yes ☐ No
24. Hemophilia ☐ Yes ☐ No
25. Anemia/blood disease ☐ Yes ☐ No
26. Cancer ☐ Yes ☐ No
27. Radiation therapy/chemotherapy ☐ Yes ☐ No
28. HIV infection/AIDS ☐ Yes ☐ No
29. Cold sores/canker sores ☐ Yes ☐ No
30. Organ transplant ☐ Yes ☐ No
31. Blood transfusion ☐ Yes ☐ No

Muscular-Skeletal/CNS/Mental Health

32. Joint replacement ☐ Yes ☐ No
33. Arthtritis ☐ Yes ☐ No
34. Osteoporosis ☐ Yes ☐ No
35. Fainting spells or dizziness ☐ Yes ☐ No
36. Seizures ☐ Yes ☐ No
37. Numbness or muscle weakness ☐ Yes ☐ No
38. Multiple sclerosis ☐ Yes ☐ No
39. Mental retardation ☐ Yes ☐ No
40. Dementia/Alzheimer's disease ☐ Yes ☐ No
41. Anxiety/Nervousness ☐ Yes ☐ No
42. Mental health treatment ☐ Yes ☐ No

Gastro-Intestinal/Genito-Urinary Health

43. Hepatitis (A, B, C or other) ☐ Yes ☐ No
44. Liver disease ☐ Yes ☐ No
45. Kidney disease/dialysis ☐ Yes ☐ No
46. Stomach trouble/ulcers ☐ Yes ☐ No
47. Sexually transmitted disease ☐ Yes ☐ No

Medication Allergies and Other Allergies

48. Penicillin or other antibiotics ☐ Yes ☐ No
49. Sulfa drugs ☐ Yes ☐ No
50. Dental antesthetic ☐ Yes ☐ No
51. Aspirin ☐ Yes ☐ No
52. Codeine/narcotics ☐ Yes ☐ No
53. Iodine ☐ Yes ☐ No
54. Latex products ☐ Yes ☐ No
55. Metals/nickels/jewelry ☐ Yes ☐ No
56. Other: ☐ Yes ☐ No

Females Only

57. Are you pregnant? ☐ Yes ☐ No
58. Are you nursing now? ☐ Yes ☐ No
59. Do you take birth control pills? ☐ Yes ☐ No

Medications

60. Are you taking any prescription medications, over the counter medications or herbal medicines? ☐ Yes ☐ No
    If so, please list them and the dose taken:

61. Do you or have you used bisphosphonate medication (Fosomax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa, Bonefos)? ☐ Yes ☐ No

Social

62. Do you use tobacco? ☐ Yes ☐ No Quantity ______ Per Day
63. Do you use alcohol? ☐ Yes ☐ No Quantity ______ ☐ Per Day ☐ Per Week
64. Do you use recreational drugs? ☐ Yes ☐ No Quantity ______ Per Day
65. Do you have any other medical conditions not already listed above? ☐ Yes ☐ No
    Please list:

I hereby certify that I have read the foregoing and filled out this questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the unsigned, consent to the performing of x-rays and examination.

Signature of PATIENT or GUARDIAN ______ Date ______

Signature of DENTIST ______ ID# ______ Date ______

UPDATE Have there been any changes in your medical history, including any medications that you take, since you last completed this form? ☐ Yes ☐ No

Signature of PATIENT or GUARDIAN ______ Date ______ Signature of DENTIST ______ Date ______

Dr. Rubencillo H. Santos, DDS, Inc.

Acknowledge of Receipt of:
Dental Materials Fact Sheet &
Notice of Privacy Practice

By signing this document, I acknowledge that I have received a copy of

Dental Materials Fact Sheet

Dr. Santos' Notice of Privacy Practice

Print Name	Signature	Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because: Individual refused to sign Communication barriers prohibited obtaining the acknowledgment Emergency situation prevented obtaining the acknowledgment

Other:____

Dr. Rubencillo H. Santos, DDS, Inc.
2503 E. Hatch Rd. Modesto, CA 95351
(209) 537-5783

DENTIST-PATIENT ARBITRATION AGREEMENT Article 1: Agreement to Arbitrate: It is understood that any dispute as to dental malpractice, that is as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. **Article 2:** All Claims Must Be Arbitrated: It is the intention of this parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified dentist, dental group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as " Dentist") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" here in shall mean both the mother and the mother's expected child or children. Filing by Dentist of any action in any court by the dentist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Dentist, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration. **Article 3:** Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Dentist, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fee and expenses. **Article 4:** Retroactive Effect: The patient intends this agreement to cover all services rendered by Dentist not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well. **Article 5:** Revocation: This agreement may be revoked by written notice delivered by Dentist within 30 days of signature and if not revoked will govern all dental services received by the patient. **Article 6:** Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law. I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I received a copy. **NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO AN IMMEDIATE JURY OR COURT TRAIL. SEE ARTICLE 1 OF THE CONTRACT.**

Print Patient Name	Signature of Patient or Legal Guardian	Date

Dr. Rubencillo H. Santos and Dr. Maria Carmela Santos Agreement to Arbitrate

In consideration of the foregoing agreements under this contract, Dr. Rubencill H. Santos, DDS and Dr. Maria Carmela Santos, DDS likewise agrees to be bound by the terms set forth in this contract and to the rules specified in Article 3 above

Print Dentist Name	Dentist Signature	Date

Patient Information Sheet

______ initials **Financial Responsibility:** I request that all benefits, if any, or other amounts payable to me or on my behalf for services rendered, be paid directly to the service provider. I understand that I am responsible for all charges for services weather or not paid by insurance. I authorize the service provider to disclose all information necessary to verify my insurance eligibility and secure the payment of benefits.

______ initials **Information Verification:** The information provided herein is true and complete to the best of my knowledge. I authorize Dr. Rubencillo H. Santos, DDS, Inc. or anyone acting behalf of the office, to obtain, review and/or share with it's designated agents, or any asignee of my account, my credit report for the purpose of evaluating my credit and verifying my identity, or for updating, renewing, servicing, modifying or collecting my account. This authorization is valid as long as any amounts are owed on my account to Dr. Rubencillo H. Santos, DDS, Inc. or any assignee of my account. I acknowledge that Dr. Rubencillo H. Santos, DDS, Inc. may report information about my account to consumer reporting agencies and other persons who may legally receive such information. Late payments, missed payments or other defaults on my account may be reflected in my credit report.

______ initials **Prior Express Consent for Calls/Texts/Email:** By providing the number of my land line, cell phone, or other wireless device and my e-mail address now or in the future, I expressly consent and agree that Dr. Rubencillo H. Santos, DDS, Inc. and any of the office's affiliates, agents, service providers or assignees may call me using an automatic telephone dialing system or otherwise, leave me a voice, prerecorded, or artificial voice message, or send me a text, email, or other electronic message for any purpose related to the servicing or collection of any account that I may establish with Rubencillo H. Santos, DDS, Inc.or for other informational purposes related to my account or treatment (Communication). I also agree that Rubencillo H. Santos, DDS, Inc. and any of the offices affiliates, agents, service providers or asignees may include my personal information in a communication. Rubencillo H. Santos, DDS, Inc. will not charge for a communication, however my service provider, may. I agree that Rubencillo H. Santos, DDS, Inc., may monitor and record any telephone calls to assure the quality of it's service or for other reasons.

Rubencillo H. Santos, DDS, Inc. will be using electronic medical records, including your photograph, to maintain your health care information. Rubencillo H. Santos, DDS, Inc. is committed to maintaining the privacy and confidentiality of patient health information in compliance with HIPAA, and will only use your photograph for internal identification purposes.
You may, at anytime withdraw your consent with written notice to Rubencillo H. Santos, DDS, Inc.

______ initials **Yes.** I agree to have my photograph taken and stored in Rubencillo H. Santos, DDS, Inc. medical records system. I understand that by checking "yes" and signing below, I am giving Rubencillo H. Santos, DDS, Inc. permission to take and use my photograph in the offices electronic medical record system for identification purposes.

______ initials **No.** I do not wish to have my photograph taken and stored in Rubencillo H. Santos, DDS, Inc. electronic medical records system.

____________________	____________________	________
Signature of patient or Guardian	printed name and relationship to patient	date

ASCEND DENTAL CARE
PATIENT CONSENT TO TREATMENT

In reading and signing this form,it is understood that ENGLISH is the language that I understand and use to communicate. **(Initials)_____**

1.DRUGS, MEDICATIONS, AND ANESTHESIA:

I understand that antibiotics, analgesic, and other medications may cause adverse reactions , some of which are, but are not limited to redness and swelling of tissues, pain,itching,vomiting,dizziness,miscarriage,cardiac arrest.

I understand that medications,drugs, and anesthetics may cause drowsiness and lack of coordination,which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, or operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of at least twenty four (24) hours after my release from surgery).

I understand that occasionally, upon injection of a local anesthetic, I may have prolonged,persistent anesthesia, numbness and/or irritation to the area of injection.

I understand that if I select to utilize Nitrous Oxide , "Atarax",Chloryl hydrate, "Zanax". Or any other sedative, possible risks include, but are not limited to, loss of consciousness,obstruction of airway, anaphylactic shock,cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 8 to 10 hours,following my dental appointment to observe possible deleterious side effects such as obstruction of airway. (Initials)______

2.HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS):

I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing and maintaining regular recall visits. (Initials)______

PERIODONTICS- I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to loss of teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and /or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction. (Initials)_______

3. REMOVAL OF TEETH:

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time.

Potential risks include, but are not limited to the following:

A. Post-operative discomfort: swelling:prolonged bleeding: tooth sensitivity to hot or cold: gum shrinkage (possibly exposing crown margins): tooth looseness: delayed healing (dry socket) and/or infection (requiring prescriptions or additional treatment, i.e. surgery).
B. Injury to adjacent teeth,caps, or fillings (requiring the recementation of crowns,replacement of fillings, fabrication of crowns, or extraction), or injury to other tissues not within the described surgical area.
C. Limitation of opening: stiffness of facial and/or neck muscles: change in bite: or temporomandibular joint (jaw joint) difficulty (possibly requiring physical therapy or surgery).
D. Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications.
E. Possible bone fracture which may require wiring or surgical treatment.
F. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
G. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin,gums,cheek,teeth, and/or tongue on the operated side: this may persist for several weeks, months, or in remote instances, permanently.

(Initials)______

I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.

If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated. I request and authorize the doctor to do whatever (s)he may deem advisable, including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility.

(Initials)______

4. FILLINGS:

I have been advised of the need for fillings, either silver or composite (plastic), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remians, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build up, and crowns), which would necessitate a separate charge.

I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines and, as such, is a treatment used by Ascend Dental Care office. The advantages of alternate materials have been explained to me. (Initials)______

5. ENDODONTIC TREATMENT (ROOT CANAL THERAPY):

The purpose and method of root canal therapy have been explained to me as well as reasonable alternative treatments, and the consequences of non-treatment. I understand that following root canal therapy my tooth will be britle and must be protected against fracture by placement of a crown (cap) over the tooth.

I understand that treatment risks can include, but are not limited to the following:

A. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.
B. Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling,either of which may persist for several days or longer.
C. Infection
D. Restricted jaw opening
E. Separation of root canal instruments during treatment, which may in the judgment of the doctor be left in the treated root canal as part of filling material, or it may require surgery for removal.
F. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.
G. Risk of temporary or permanent numbness in treatment area.

If an "open and medicate" or pulpotomy procedure is performed. I understand that this is not permanent treatment, and I need to pay for, and finish final root canal therapy. If root canal treatment is not finalized I expose myself to infection and/or tooth loss.

If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted.

(Initials)_____

6. CROWN AND BRIDGE (CAPS):

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy.

I understand that like natural teeth, crowns and bridges need to be kept clean with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment.

(Initials)______

7. DENTURES – COMPLETE OR PARTIAL:

The problems of wearing dentures has been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Follow- up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor.

I further understand that surgical intervention (i.e. tori (bone)removal, bone recountouring, or implants) may be needed for dentures to be properly fitted.. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction.

(Initials)_______

8. PEDODONTICS (CHILD DENTISTRY):

I understand that the following are routinely used at Ascend Dental Care office, as well as being accepted procedures in the dental profession.

A. POSITIVE REINFORCEMENT- Rewarding the child who portrays desirable behavior, by use of compliments, praise, a pat or hug, and/or token objects or toys.
B. VOICE CONTROL- The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctors' voice.
C. PHYSICAL RESTRAINT- Restraining the child's disruptive movements by holding down their hands, upper body, head, and/or legs by use of the dentist's or assistant's hand or arm, or by use of a special device (referred to as a "papoose board").
D. .NITROUS OXIDE AND/OR ORAL SEDATION- Nitrous oxide is a mild gas that is mixed with oxygen, and is used to sedate a a person. It is administered through a mask placed over the child's nose. Oral sedation are medications administered to children to help them relax. With their use the parent/guardian must understand that the child should not eat or drink for a period of four hours prior to the sedation procedure , and observe their behavior throughout the day.

I understand that with the use of an injection used to numb the tooth area for dental procedures, the possibility exists that the child may inadvertently bite their lip causing injury to occur.

I understand the need to return to the office for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time.

I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation and the possibility of it needing an extraction. (Initials)_______

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HER/HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE.I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND I HAVE HAD THEM ANSWERED TO MY SATISFACTION.

I UNDERSTAND THAT ASCEND DENTAL CARE PROVIDES DENTAL CARE SERVICES WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY, AGE OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF ITS PATIENTS.

Signature:_______________________________ Relationship:_______________________ Date: ____/____/_____
Patient or Legal Representative

Doctor:_______________________________________ Witness:_______________________________