KAI FAMILY DENTISTRY
550 Water Street, Suite I-5, Santa Cruz
Phone: (831) 429-9614 | Fax: (831) 429-9615

CONSENT FOR TREATMENT

Diagnostics I hereby authorize Dr. Lynda Tran or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by Dr. Lynda Tran to make a thorough diagnosis of _____'s dental needs.
Patient's Name

Treatment Upon such diagnosis, I authorize Dr. Lynda Tran to perform recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Anesthetics I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Information Disclosure I give consent to Dr. Lynda Tran or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine or the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

Financial I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

_____ Patient Signature _____ Date _____ Witness Name & Signature

_____ Parent/Guardian Signature _____ Relationship to Patient

_____ Patient's Initials

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet
I acknowledge I have received a copy of the Dental Material Fact Sheet.

_____ Patient's Initials

Patient Acknowledgement of Receipt of Notice of Privacy Practices
I acknowledge I have received a copy of the Notice of Privacy Practices.

_____ Patient's Initials

Limited Release Allowing Communication of Information
I give permission for my account and treatment needs information to be discussed with the person/persons noted:

Name of Person/Persons: _____