

MATTHEW RYAN, D. D. S.

PERSONAL INFORMATION

FULL LEGAL NAME _____ DATE OF BIRTH _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE: HOME _____ WORK _____ MOBILE _____

EMAIL _____

SOCIAL SECURITY NUMBER OR ID NUMBER _____

EMERGENCY CONTACT PERSON _____ RELATIONSHIP _____

EMERGENCY PHONE NUMBER(S) _____

RESPONSIBLE PARTY INFORMATION

DENTAL INSURANCE PROVIDER _____ GROUP/PLAN NAME/NUMBER _____

EMPLOYER (subscriber's employer, if applicable) _____

EMPLOYER ADDRESS (of subscriber) _____

EMPLOYEE/SUBSCRIBER NAME (if different than above) _____

EMPLOYEE/SUBSCRIBER SOCIAL SECURITY OR ID NUMBER (if different than above) _____

SECONDARY DENTAL INSURANCE PROVIDER _____ GROUP/PLAN NAME/NUMBER _____

EMPLOYER (subscriber's employer, if applicable) _____

EMPLOYER ADDRESS (of subscriber) _____

EMPLOYEE/SUBSCRIBER NAME (if different than above) _____

EMPLOYEE/SUBSCRIBER SOCIAL SECURITY OR ID NUMBER (if different than above) _____

AUTHORIZATION AND SIGNATURES ON FILE

I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. To the extent permitted by law, I consent to the use and disclosure of my protected health information to carry out payment activities. I certify that the information I have provided is correct to the best of my knowledge. I will notify you of any changes in the above information.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Matthew Ryan, D.D.S.

I retain the right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

SIGNATURE: _____ **DATE:** _____

MATTHEW RYAN, D. D. S.

REQUEST AND CONSENT FOR DENTAL TREATMENT

I request and authorize Matthew Ryan, D.D.S., and whomever he may designate as his assistant(s), to perform the treatment and procedures outlined on my plan of care. I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary and/or advisable to treat my dental conditions.

I have had explained to me and I have had sufficient opportunity to discuss my dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment. In addition, I have received a copy of the Dental Board of California's *Dental Materials Fact Sheet* dated May 2004, as required by law.

The usual and most frequently occurring risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include, but are not limited to, the possibility of pain or discomfort during and following treatment, swelling, bleeding, injury to adjacent teeth and surrounding tissue, development of transient or permanent temporomandibular joint (TMJ) disorder, temporary or permanent numbness, and allergic reactions.

I understand that during the course of my dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on my plan of care. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made concerning the results of the dental treatment that I will receive.

All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for me on the plan of care. I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

SIGNATURE OF PERSON CONSENTING TO TREATMENT: _____

DATE: _____

IF OTHER THAN THE PATIENT, INDICATE RELATIONSHIP: _____

DENTIST CERTIFICATION

I certify that I have explained the nature, purpose, benefits, the usual and most frequent risks and hazards of, and alternatives to, the treatment and procedures prescribed on the plan of care dated _____. I have offered to answer any questions and have fully answered such questions. I believe the patient/guardian understands what I have explained and has consented to the proposed treatment and procedures.

SIGNATURE: _____ DATE: _____

WITNESS CERTIFICATION

I certify that the patient either: has acknowledged that he/she has received an explanation of, and alternatives to, proposed treatment/procedures; has had all of his/her questions answered; has given his/her consent; and has signed this form where indicated.

SIGNATURE: _____ PRINT NAME: _____

DATE: _____