NORTHWEST DENTAL MEDICINE
2903 E. Main, Puyallup, WA 98372
Office: (253) 845-9507

Name of Patient: _____ Date of Birth: _____

How did you learn of this office: _____

GENERAL CONSENT & AUTHORIZATION

In signing and providing this document to NORTHWEST DENTAL MEDICINE, you are confirming that the information provided to us on your behalf (including your medical and dental health and history) is accurate and complete, and that you are providing the consents hereunder on a continuing basis and agree to the terms and conditions of this document. You further agree to promptly notify us of any changes in your health and medications (medical and/or dental). In addition to medical/dental radiographs, intra-oral and/or extra-oral photographs may be taken of you by us in an effort to enhance our understanding of a medical/dental condition that may be present and/or for professional medical/dental/insurance consultation/education, and you consent to the taking of any such photographs. No marketing or other distribution of any photographs will be undertaken without your prior consent.

_____ **(Initial) Conversations with you within our office may also be recorded** by us, in an effort to enhance the understanding of our services provided to you and for purposes of treatment, and you consent to any such recordings. You further acknowledge and confirm on a continuing basis the following:

- You have been completely forthcoming with the information provided to us on your behalf.
- You will promptly notify us of any changes in your health and medications (both medical and dental).
- The dentists/doctors of Northwest Dental Medicine and/or designated associate(s) and/or assistants may produce and distribute radiographs, photographs, and/or other professionally related documents of you to insurance companies, legal entities, dental examination boards, and dental specialists.
- Except to the extent you otherwise notify us in advance, you hereby authorize the dentists/doctors of Northwest Dental Medicine and/or designated associate(s) and/or assistant(s) to perform any and all procedures any of them believe are reasonably necessary as part of rendering a diagnosis and treatment services to you. By consenting to examinations and/or recommended treatment, you further authorize the dentists/doctors of Northwest Dental Medicine and/or designated associate(s) and/or assistant(s) to administer local anesthetics to you and to render treatment to you. If the patient is a minor (under the age of 18 in the State of Washington), as the guardian therefor you permit and authorize the dentists/doctors of Northwest Dental Medicine and/or designated associate(s) and/or assistant(s) to perform treatment and procedures on the minor whether or not you are present at the appointment or when services are rendered.

I further authorize the release of information related to me and my medical/condition, as well as treatment received by or through this office, to be communicated via oral, written, and/or other means to the following other than myself:

Name:	Relationship:	Name:	Relationship:
_____	_____	_____	_____

The consent and authorization will remain fully effective until revoked by you in writing and received by us. You have the right to discuss your treatment plans and options with us, and if you have any question or concern about this document or any treatment or service you receive from us, we encourage you to ask us questions.

By signing below, I certify that I have read and fully understand this document and consent and agree fully and voluntarily to its contents.

Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____