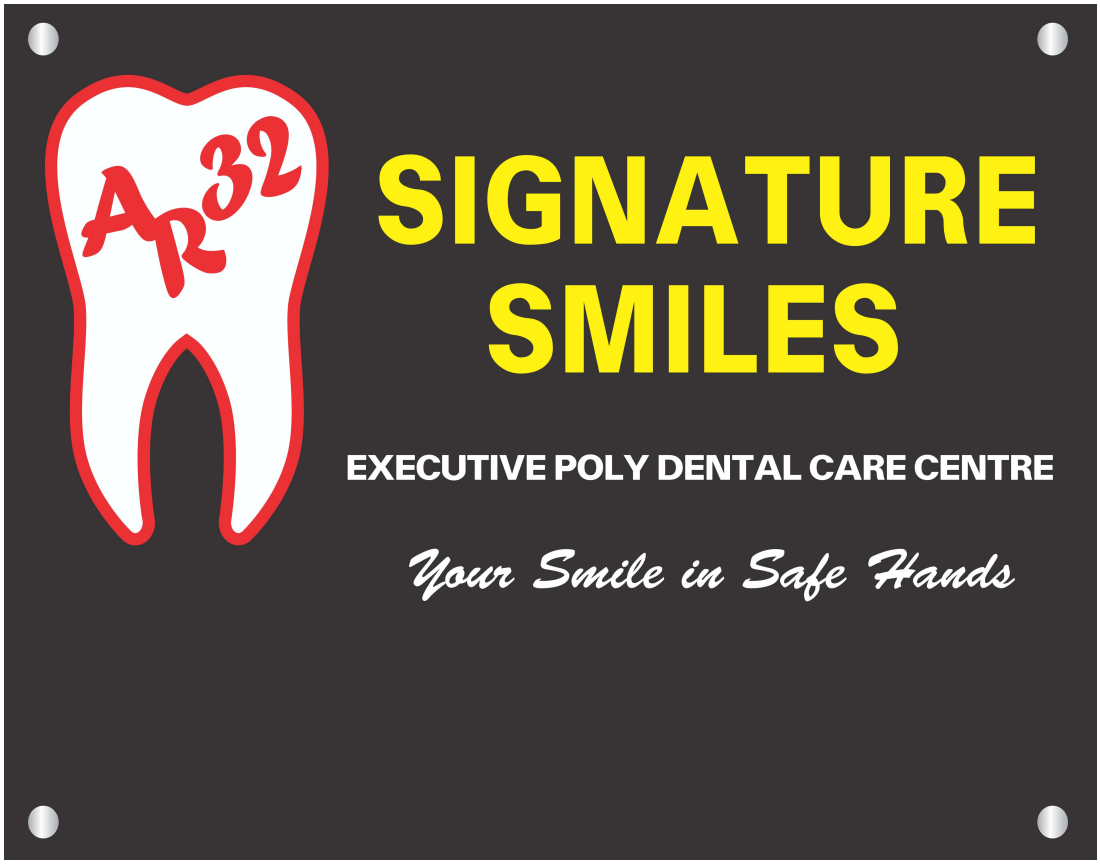

AR 32 SIGNATURE SMILES EXECUTIVE POLY DENTAL CARE CENRE

Clinic add :- *2nd Floor, Above Moonlight Photo studio, Next to Mahanagar bank, Landmark: Near Tata Guard room BRT Bus stop, Pune-Nagar Highway, Kharadi, Pune 411014*

Dr Avinash Bamane A-18814

Contact :- *8806631888 / 9503507825*

Dr Rashmi Bamane *A-22726*

1. ***Patients name :-***
2. ***Age / Gender :-***
3. ***Date of Birth :-***
4. ***Contact No :-*** *(M)*

   Additional Contact No :-
5. ***Mail ID :-***
6. ***Permanent Full Address :***
7. KYC Document Submitted :-

   ☐ *ID Proof*

   ☐ *Address Proof*

   ☐ *2 Copies Photos*

MEDICAL HEALTH HISTORY

☐ **Have you undergone dental treatment before ..... ?**

Do you have, or have you had any of the following?

(Please check any that apply)

☐ **Are you required to Pre-medicate before any dental treatment ?**

☐ Blood Problems (Anemia)

☐ Blood transfusion

☐ Heart problems

☐ Stroke

☐ Bone or Joint problems

☐ Artificial joint or valves

☐ High blood pressure

☐ Low blood pressure

☐ Tuberculosis or other lung problems

☐ Kidney disease

☐ Hepatitis, Jaundice, liver issues

☐ Diabetes TYPE 1 or TYPE 2

☐ Epilepsy or Neurological disorders

☐ Thyroid problems

☐ Arthritis

☐ Herpes

☐ AIDS or HIV positive

☐ Cancer / Tumor

☐ Abnormal bleeding after any surgery

☐ Maxillary Sinus trouble or Hay fever

☐ Allergies

☐ Asthma

Do you smoke,vape or use tobacco ?

☐ Yes

☐ No

Are you Allergic to, or have you reacted adversely to any of the following?

☐ Latex

☐ Penicillin or other antibiotics

☐ Local anesthetics

☐ Codeine or other narcotics

☐ Sulfa drugs

☐ Barbiturates, sedatives, or sleeping pills

☐ Aspirin

Other:_____

Are you taking any of the following?

☐ Aspirin

☐ Anticoagulants (blood thinners)

☐ Antibiotics or sulfa drugs

☐ High blood pressure medicine

☐ Antidepressants or tranquilizers

☐ Insulin other diabetes drugs

☐ Nitroglycerin Cortisone or other steroids

☐ Osteoporosis (bone density) medicine

☐ Natural supplements

☐ Other:_____

Women:

☐ Are your pregnant

☐ plant to become pregnant

☐ Taking hormones or contraceptives

☐ Lactating / Breast Feeding

General dentistry informed consent

You have the right and the obligation to make decisions regarding your healthcare. Your dentist can provide you with the necessary information and advice, but as a member of the healthcare team, you must participate in the decision-making process. This form will acknowledge your consent to treatment recommended by your dentist.

1. Work to be done : *I understand that I am having the following work done [Indicate all services being provided]: X-rays, Scaling, Fillings, Root Canals, Crowns & Bridges, Extractions, Impacted teeth removal, Dental Implant, Dentures, Other Treatment as & when required .*

2. Drugs and medications : *I understand that antibiotics, analgesics and other medications may cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. I have advised my dentist of any and all medications I am currently taking, including but not limited to prescription medications, over-the-counter medications, herbal remedies, and alternative medications. I further understand that failure to advise my dentist of any medications I am taking prior to starting dental work may have unforeseen negative consequences for me.*

3. Changes in treatment plan : *I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discoverable during previous examinations. For example, root canal therapy may be necessary following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary. These changes will be discussed with me and I will have the opportunity to verbally agree or decline the change in treatment, unless it is not practical due to a dental/ medical emergency.*

3. Removal of teeth : *Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.), and I authorize the dentist to remove the teeth as planned and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment.*

5. Crowns, bridges and caps : I understand that sometimes it is not possible to match the colour of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered.

I realize the final opportunity to make changes in my new crowns, bridge, or cap (including shape, fit, and colour) will occur only before final cementation. It is also my responsibility to return for permanent cementation within 21 days from initial tooth preparation. Excessive delays may allow for tooth movement or additional decay which may necessitate a remake of the crown, bridge, or cap. In such instances, I understand that there will be additional charges for remakes due to my delaying permanent cementation.

6. Endodontic treatment (root canal) : *I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to break in my tooth during treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicectomy), or the root canal may be short or have other complications and may need to be redone. My root might also be perforated during the procedure causing me to lose the tooth. I understand that the tooth may be lost in spite of all efforts to save it and that a root canal is not a guarantee the tooth will be saved.*

7. Periodontal loss (tissue and bone) : *I understand that if I am being treated for periodontal disease, this means I have a serious condition, causing gum and bone inflammation or loss and that it can ultimately lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that any dental procedure may have a future adverse effect on my periodontal condition.*

7. Fillings : *To avoid breakage, I understand that care must be taken when chewing on fillings, especially during the first 24 hours. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that increased sensitivity is a common effect of a newly placed filling.*

9. Dentures : *I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems associated with dentures. Immediate dentures (placement of denture immediately after extractions) may be painful. In addition, immediate dentures often require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delay of 30 days or more, there may be additional charges assessed against me.*

10. Dental Implants : ***I request and authorize Dr. or his/her associates or assistants to perform the surgical placement of dental implants upon me. This procedure has been recommended to me by my dentist as an option to replace my natural teeth. Dental implants are metal anchors put inside the jawbone underneath the gum line. Small posts are attached to the implants and artificial teeth or dentures are fastened to the posts. Most patients need two surgical procedures to install the implants. The first procedure involves drilling small holes into the jawbone and placing the anchors. A temporary denture may be worn for a few months while the anchors bond with the jawbone and the gums and bone heal. The second procedure will uncover the implants to allow for attachment of the posts. After the posts are in place, the replacement teeth, in the form of fixed or removable bridgework or a denture, are fastened to the posts. Depending on the condition of the mouth, bone grafting or guided tissue regeneration also might be necessary to install the anchors and posts. The potential benefits of this procedure include the replacement of missing natural teeth or supporting dentures. I authorize placement of implants in the areas of teeth as planned.***

I understand the risks involved with dental Treatments, some of which are

- *pain, swelling, spreading of infection, dry socket, and loss of feeling in my teeth, lips, tongue and surrounding tissue (Paraesthesia) that can be temporary or permanent, and fractured jaw. Restricted ability to open the mouth because of swelling and muscle soreness or stress on the joints in the jaw – temporo-mandibular joint (TMJ) syndrome*
- *Fracture of the jaw*
- *Bone loss of the jaw*
- *Penetration into the sinus cavity*
- *Mechanical failure of the anchors, posts, or attached teeth*
- *Failure to implant itself*
- *Allergic or adverse reaction to any medications Most of these risks, complications or side effects are not serious and do not occur frequently.*

Although these risks, complications and side effects occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the dentist performing the procedure. Although most procedures have good results, I acknowledge that no guarantee has been made to me about the results of this procedure or the occurrence of any risks, complications or side effects.

These potential risks and complications could result in the need to repeat the procedures; remove the implants; or undergo additional dental, medical or surgical treatment or procedures, hospitalization or blood transfusions. Very rarely, the potential risk and complications could result in permanent numbness, disability or death.

I recognize that during the course of treatment, unforeseeable conditions may require additional treatment or procedures. I request and authorize my dentist and other qualified medical personnel to perform such treatment as required.

Consent for oral sedation/anesthesia

I have requested an oral sedative: Valium, Halcion, Ativan, (other) with a planned dosage to help relieve anxiety and/or apprehension. I understand the sedative may cause dizziness, drowsiness, time constriction, motor incoordination and fatigue.

I understand that I must have a responsible adult transport me to the office and home afterward. I understand that I will be under the influence of the sedative for 8 to 10 hours and agree to stay at home under the supervision of an adult, and will not attempt to drive, supervise or care for children, or perform anything that requires coordination or personal judgment. I understand that I can NOT have any alcohol, tranquilizers or other sedatives on the day of the treatment — either before or after treatment.

Anesthesia includes:

Local anesthesia: Novocain, Lidocaine, etc., to block pain pathways in a localized area (by injection)
Local intravenous sedation or general anesthesia: alters your awareness of the procedure by producing sedative/amnesic effects or sleep

I understand there are risks involved with both anesthesia and oral sedation that can include but are not limited to:

- Nausea and vomiting
- Temporary or permanent partial numbness to face or tongue
- Unexpected allergic reaction
- Pain, swelling, bruising or inflammation to the area of injection
- Prolonged disorientation, confusion or drowsiness after treatment
- Respiratory or cardiovascular responses that can lead to stroke, heart attack or death
- Falls caused by instability post-ingestion.

I also understand and agree that prior to any anesthesia, I will not ingest any fluids or solids by mouth for six (6) hours prior to the dental procedure, as this could be life-threatening.

I understand that I must have a responsible adult transport me to the office and home afterward. I understand that I will be under the influence of the sedative for 8 to 10 hours and agree to stay at home under the supervision of an adult, and will not attempt to drive, supervise or care for children, or perform anythingthat requires coordination or personal judgment.

I also agree that I have provided a complete and truthful medical history that includes all medications, drug use, pregnancy, etc.

We invite your questions concerning this or related procedures and their risks. By signing below you acknowledge that you have read this document, understand the information presented, understand that you could see a specialist but are choosing care from the treating dentist, and have had all your questions answered satisfactorily.

Patient Progress Notes

Date	TREATMENT	Charges

Agreement to Receive Electronic Communication

I DO AGREE , That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

Mymostpreferredmethodofelectroniccommunication:

- Text Messaging
- Email

I would like to receive:

- Appointment Reminders/Recall Visits
- Information regarding insurance/billing
- Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at anytime by calling:

No show, missed appointment office policy form

When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule your appointment, that you please provide us with at least 24 hours notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

There is a charge of Rs 500 per hour or 30 % of next treatment planned for not showing up for scheduled appointments.

Repeated cancellations or missed appointments will result in loss of future appointment privileges.

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

PATIENT PAYMENT AGREEMENT

Thank you for the opportunity to help you meet your oral health goals. During our discussion of your treatment recommendation and our Written Financial Policy, the following financial arrangements were made:

The cost of treatment with this dental clinic is Rs._____. Once dental treatment has begun, changes in the anticipated treatment plan may be required, depending on oral conditions encountered. We will inform you if this occurs and you will be given the option of continuing or changing treatment.

I have discussed payment options and agreed upon a payment plan with the insurance company and with the undersigned provider. In the case that my insurance does not reimburse the full amount noted on the Treatment Plan, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

As you know, it is this practice's policy to receive payment prior to completion of treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. You have agreed to pay your patient portion of the treatment fee in the following way:

Payment in full in the amount of Rs.

Remaining treatment fee: Rs.

To be paid by Equal payments of Rs.

If you have questions about your treatment plan or the choice of payment options, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Date :-

_____ _____

Doctor's signature

Dr Avinash Bamane A-18814

Dr Rashmi Bamane A-22726

Patient's signature
or
legally authorized representative
(Relationship & name if signed on behalf of the patient)

I understand that dentistry is an inexact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) which I have requested and authorized.

I hereby authorize any of the doctors or dental assistants or auxiliaries to proceed with and perform the dental restorations and treatments indicated above and as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I may be responsible for payment of the dental fees.