PREVENTION WORKS
1460 OUTER HAMMOND STREET
BANGOR ME. 04401

I, _____, consent to be a patient at Prevention Works and agree to a clinical assessment by an independent dental hygienist. I understand that this is not a dentist and the services rendered do not constitute restorative care or treatment. **I also understand and consent to the following:**

1. During the course of preventative care, I may undergo procedures in all phases of preventive dentistry including: periodontics (scaling and root planing), periodontal maintenance, periodontal charting, x-rays, regular cleanings, fluoride, sealants and temporary sedative fillings if applicable.
2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my provider communicating with my other medical practitioners to inquire about any aspect of my health history.
3. No guarantees can be made about treatment outcomes. Treatment plans are subject to change at any time.
4. I will pay in full any cost of treatment or insurance copayments according to the offices' financial policy. I understand that even if the insurance pre-estimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.
5. Failed appointments, appointments canceled without a 48-hour notice, and returned checks may be subject to a fee.

_____ _____
Patient or Guardian Name Date

_____ _____
Witness Date

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO RELEASE PAYMENT FOR SERVICES TO PREVENTION WORKS.

INSURED SIGNATURE: _____ DATE:_____

I authorize my dental provider to receive and release any information regarding my treatment. Also, in accordance with HIPAA regulations of 1996, I hereby authorize Prevention Works to release information, such as financial, appointment and personal information, as needed, to the following people/institution (check all that apply):

__ Dental Carrier __ Spouse __Parents __Medical Office __Secretary __Other

Signature: _____ Date: _____