LAKESIDE DENTAL
FAMILY & COSMETIC DENTISTRY

PATIENT REGISTRATION FORM

I. PATIENT INFORMATION

TODAY'S DATE: _____ OFFICE USE ONLY: ☐ New Patient ☐ Existing Patient Verified Gov't Issued ID: ☐ Yes ☐ No

PATIENT NAME: _____ PATIENT'S DATE OF BIRTH: _____
Last Name First Name Middle Initial

HOME ADDRESS: _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

CITY: _____ STATE: _____ ZIP: _____ ☐ Separated ☐ Divorced ☐ Partnered for ___ years

PATIENT'S PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Other _____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT: _____ RESPONSIBLE PARTY'S DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____

HOW DID YOU FIND US? ☐ Google Search ☐ Google Maps ☐ Friend ☐ Family ☐ Existing Patient ☐ Insurance Website ☐ Physician/Specialist Referral
☐ Drive By ☐ Social Media ☐ Other _____

IF APPLICABLE, WHOM CAN WE THANK FOR REFERRING YOU? _____

II. CONTACT INFORMATION

HOME PHONE: _____ CELL PHONE: _____ E-MAIL: _____

WORK PHONE: _____ EXTENSION: _____ SPOUSE/PARENT CELL: _____

PREFERRED METHOD OF CONTACT: ☐ Text ☐ E-mail ☐ Phone

May we send text messages regarding treatment and billing? ☐ Yes ☐ No
May we send e-mails regarding treatment and billing? ☐ Yes ☐ No
May we leave detailed voicemails regarding treatment and billing? ☐ Yes ☐ No

EMERGENCY CONTACT: _____ LIVES WITH PATIENT: ☐ Yes ☐ No

RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ CELL PHONE: _____ WORK: PHONE: _____

III. DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

DOES PATIENT HAVE DENTAL INSURANCE? ☐ YES ☐ NO

PATIENT'S SOCIAL SECURITY NUMBER: _____

POLICY HOLDER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

INSURANCE COMPANY _____

ID# _____ PHONE: _____

SECONDARY INSURANCE

IS PATIENT COVERED BY SECONDARY INSURANCE? ☐ YES ☐ NO

POLICY HOLDER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

INSURANCE COMPANY _____

ID# _____ PHONE: _____

I certify that the information provided is accurate and complete to the best of my knowledge.
I understand it is my responsibility to notify Lakeside Dental of changes to my contact information, insurance coverage, or personal information.

PATIENT OR PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

LAKESIDE DENTAL
FAMILY & COSMETIC DENTISTRY

DENTAL & HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. DENTAL HISTORY

Why have you come to see us today? ☐ Relief of pain ☐ Preventive care ☐ Improve my smile ☐ Replace missing teeth ☐ Improve chewing ☐ Second opinion ☐ Other _____

Former Dentist/Dental Office: _____ Date of most recent dental exam: _____

Reasons for changing dentists? _____ Date of most recent dental treatment: _____

Please select Yes or No for every question. If you do not understand a question, please ask a member of our team for assistance.

1. Yes No I currently have pain with my teeth, gums, or mouth.
2. Yes No I have problems eating.
3. Yes No I avoid brushing part of my mouth due to pain.
4. Yes No I have loose or broken teeth or fillings.
5. Yes No I have sores or growths in my mouth.
6. Yes No My gums bleed while brushing or flossing.
7. Yes No I have had periodontal treatment or a deep cleaning.
8. Yes No I have had facial or jaw injury or surgery.
9. Yes No I have had braces or orthodontic treatment in the past.
10. Yes No I have trouble getting/staying numb with dental treatment.
11. Yes No My jaw clicks, pops, locks, becomes tired, or is painful.
12. Yes No My teeth are sensitive to hot, cold, and/or sweets.
13. Yes No I have sensitivity, discomfort, or pain when biting or chewing.
14. Yes No I clench or grind my teeth during the day or while sleeping.
15. Yes No I have dry mouth.
16. Yes No I have had oral cancer, precancerous lesions, or abnormal biopsies.
17. Yes No I have family history of oral cancer, precancerous lesions, or abnormal biopsies.
18. Yes No I want to change or improve my smile.
19. Yes No I want to straighten my teeth.
20. Yes No I want to whiten my teeth.

21. Have you ever had other problems with or complications after dental treatment, including dental implants? Yes No If so, please explain: _____

22. How often do you floss? ☐ Never ☐ Less than once a week ☐ 1-3 times per week ☐ 4-6 times per week ☐ Daily or more

23. How often do you brush? ☐ Less than once daily ☐ Once daily ☐ Twice daily ☐ More than twice daily

24. Is there anything else you would like us to know about your dental care or today's visit? _____

II. HEALTH HISTORY

Primary Care Physician's Name: _____ Date of most recent visit: _____

Preferred Pharmacy Name:_____ Address:_____ Phone: _____

INDICATE IF YOU HAVE OR HAVE HAD THE FOLLOWING CONDITIONS, OR IF YOU ARE TAKING OR HAVE TAKEN THESE DRUGS:

25. Yes No High blood pressure
26. Yes No Heart attack
27. Yes No Heart murmur
28. Yes No Irregular heartbeat or AFib
29. Yes No Congenital heart defect
30. Yes No Prosthetic heart valve
31. Yes No Pacemaker or implanted cardiac device
32. Yes No Congestive heart failure
33. Yes No Other heart disease or problems
34. Yes No Anemia
35. Yes No Hemophilia, other bleeding issues
36. Yes No Blood transfusions
37. Yes No Blood thinner medication(s)
(Eliquis, Xarelto, Plavix, Warfarin/Coumadin)
Name of Medication _____
38. Yes No High Cholesterol
39. Yes No Stroke, TIA
40. Yes No Diabetes ☐ Type I ☐ Type 2
Most Recent HbA1c_____ Date_____
41. Yes No GLP-1 Medications
42. Yes No Asthma
43. Yes No Sleep Apnea
☐ CPAP ☐ Oral Appliance ☐ Implanted Device
44. Yes No COPD, Emphysema, Chronic Bronchitis
45. Yes No Tuberculosis
46. Yes No Other respiratory problems
47. Yes No Cancer
Type _____ Date_____
48. Yes No Chemotherapy
49. Yes No Radiation
50. Yes No Kidney Disease
51. Yes No Liver Disease
52. Yes No Hepatitis Type _____
53. Yes No Thyroid or adrenal problems
54. Yes No Organ transplant
55. Yes No Osteoporosis or related medication(s)
(Fosamax, Boniva, Actonel, Reclast, Prolia, Xgeva, Zometa)
If Yes, which medication(s):_____
☐ Currently Taking ☐ Previously Took
Administration Route: ☐ Oral ☐ Injection ☐ IV
56. Yes No Artificial joint
57. Yes No Dementia / Alzheimer's
58. Yes No Anxiety, depression, other psychiatric care
59. Yes No Sinus problems
60. Yes No Stomach problems, ulcers
61. Yes No Epilepsy or seizures
62. Yes No Fainting or dizziness
63. Yes No Glaucoma or other eye diseases
64. Yes No Autoimmune disorders (Sjögren's, Hashimoto's, etc)
65. Yes No Skin diseases
66. Yes No Herpes / Cold Sores
67. Yes No HIV/AIDS
68. Yes No Sexually transmitted infections (HPV, syphilis, etc.)
69. Yes No Tobacco / Nicotine in any form
If yes, ☐ Former ☐ Current
TYPE(S): ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless ☐ Vape
70. Yes No Alcohol ☐ Occasional ☐ Weekly ☐ Daily
71. Yes No Marijuana, cannabis, or recreational drugs
If yes, ☐ Former ☐ Current
TYPE(S): _____

72. Yes No Current prescription and/or over-the-counter medications, vitamins and supplements, natural remedies? If yes, please list: _____

73. Yes No Medication Allergies: ☐ Penicillin ☐ Azithromycin ☐ Clindamycin ☐ Other medications: _____
74. Yes No Other allergies: ☐ Latex ☐ Adhesives ☐ Metals ☐ Foods ☐ Other:_____ Reaction: _____
75. Yes No Direction from physician to avoid: ☐ Ibuprofen or other NSAIDs ☐ Acetaminophen/Tylenol ☐ Other pain medications ☐ Antibiotics ☐ Other:_____
76. Yes No Surgeries Please list each surgery and year they were performed _____
77. Yes No Other medical conditions, problems, or medical history NOT already listed on this form? If so, please describe: _____

WOMEN'S REPRODUCTIVE HEALTH:

78. Yes No Taking birth control
79. Yes No ☐ Pregnant ☐ Possibly Pregnant ☐ Trying to Become Pregnant ☐ Nursing Estimated due date, if applicable: _____

I certify that the information provided is complete and accurate to the best of my knowledge. I understand that my medical and dental history, medications and allergies may affect the dental care I receive. I agree to notify Lakeside Dental of any changes in my health, medications, allergies or pregnancy status. I understand that the dentist or dental team may ask additional questions or request consultation with another healthcare provider when appropriate.

Patient's / Guardian's signature: _____ Doctor's signature: _____ Date: _____

FINANCIAL POLICY & APPOINTMENT AGREEMENT

LAKESIDE DENTAL
FAMILY & COSMETIC DENTISTRY

Thank you for choosing Lakeside Dental. Our goal is to provide exceptional dental care in a transparent, respectful, and efficient manner. To help us provide the best possible experience for every patient, please review the following financial and scheduling policies.

APPOINTMENT CONFIRMATION & ARRIVAL POLICY

As a courtesy, we may contact you by phone, text message, email, or other electronic communication to remind you of upcoming appointments. Confirming your appointment helps us reduce unnecessary reminder messages and allows us to reserve time efficiently for all patients. **Failure to confirm an appointment may result in the appointment being released and rescheduled.**

Your scheduled appointment time is the time we anticipate seating you and beginning your treatment. To ensure your appointment starts on time, **please arrive 5–10 minutes early**. If you need to update your medical history, insurance information, or patient forms, please **complete them before your appointment or arrive at least 20 minutes early**.

We understand that delays and emergencies occasionally occur. While we will make every reasonable effort to accommodate late arrivals, **arriving late may require shortening or rescheduling your appointment** in order to remain on schedule for other patients.

CANCELLATION & MISSED APPOINTMENT POLICY

We kindly request at least **24 hours or one full business day's notice** (whichever is greater) if you need **to cancel or reschedule** an appointment. Providing advance notice allows us the opportunity to offer your reserved appointment time to another patient awaiting care. We understand that illness, emergencies, and unexpected situations occur and will always take those circumstances into consideration. However, **repeated missed appointments or cancellations with insufficient notice** may result in a **missed appointment fee of $50 or more**, depending on the amount of time reserved.

Appointments lasting **more than two hours** or involving treatment **exceeding $2,000** may require a **deposit of 20%–50%** to reserve the appointment time. Deposits are applied toward the total cost of treatment. **Missed appointments or cancellations without the required notice may result in forfeiture of all or part of the deposit**, except where prohibited by law.

If circumstances beyond our control—including severe weather, illness, equipment failure, or other emergencies—require us to reschedule your appointment, we will provide as much advance notice as reasonably possible.

FINANCIAL RESPONSIBILITY

Payment is due at the time services are provided unless prior financial arrangements have been approved. Emergency treatment or treatment performed without prior financial arrangements must be paid for at the time of service. As a courtesy, Lakeside Dental will gladly submit insurance claims and assist in verifying your insurance benefits whenever possible. Benefit estimates are provided solely as a courtesy and are not guarantees of payment.

While we make every effort to provide accurate treatment estimates and insurance projections, **insurance companies do not always provide us with complete or accurate information**. Insurance policies vary significantly and may contain limitations, exclusions, waiting periods, annual maximums, deductibles, downgrades, coordination of benefits, or other provisions. **Insurance carriers may also reduce or deny payment for completed treatment for reasons not previously disclosed to our office**. As a result, estimated patient portions may change. **Patients are ultimately responsible for all fees associated with their treatment regardless of insurance coverage or payment**.

Patient responsibility may include, but is not limited to:

- Deductibles
- Copayments
- Coinsurance
- Annual maximums
- Non-covered services
- Downgraded procedures
- Services denied by insurance

While we are happy to assist with benefit verification and claim submission, patients remain responsible for understanding their insurance coverage, deductibles, annual maximums, exclusions, and claim status.

Patients are responsible for notifying Lakeside Dental of any changes to their insurance coverage before treatment is provided. Balances remaining unpaid for more than 60 days may be subject to a finance charge of 1.5% per month (18% annually) unless prior payment arrangements have been approved.

Where permitted by law, delinquent accounts may also incur statement fees, returned payment fees, collection costs, reasonable attorney's fees, court costs, and other expenses associated with collection of the account.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and authorize payment of my dental insurance benefits directly to Lakeside Dental for services provided to me or my dependents. I authorize Lakeside Dental to submit insurance claims on my behalf and to release to my insurance carrier, its

representatives, or other third-party payers any information necessary to determine benefits, process claims, or obtain payment for services rendered.

I understand that:

- Assignment of benefits does not guarantee payment by my insurance company.
- I remain financially responsible for all charges not paid by my insurance carrier.
- If my insurance company issues payment directly to me for services provided by Lakeside Dental, I agree to promptly remit those funds to the practice if a balance remains outstanding.

RETURNED OR REVERSED PAYMENTS

Any returned check, declined credit or debit card transaction, chargeback, ACH return, or other reversed payment may be subject to applicable fees and immediate repayment of the outstanding balance.

COMMUNICATION AUTHORIZATION

By signing below, I authorize Lakeside Dental to contact me by telephone, voicemail, text message, email, postal mail, or other electronic communication regarding:

- Appointment reminders ● Missed appointments ● Follow-up care ● Treatment recommendations
- Preventive care reminders ● Insurance matters ● Billing and payment information
- Other healthcare-related communications

I also authorize Lakeside Dental to release the minimum necessary treatment and financial information to insurance companies, third-party payers, financing companies, or collection agencies as necessary for payment, claims processing, or healthcare operations, as permitted by applicable law.

PATIENT AGREEMENT

By signing below, I acknowledge and agree that:

- I have read and understand this Financial Policy and Appointment Agreement.
- I have had the opportunity to ask questions and have received satisfactory answers.
- I understand that I am ultimately responsible for payment of all charges incurred for dental treatment provided to me or my dependent(s), regardless of insurance coverage.
- I authorize the Assignment of Insurance Benefits described above.
- I agree to notify Lakeside Dental of any changes to my contact information, medical history, or insurance coverage.
- I agree to comply with the policies described in this Agreement.

PATIENT INFORMATION

Patient Name (Print): _____

If the patient is a minor or lacks legal capacity:

Parent, Legal Guardian, or Personal Representative:_____

Relationship to Patient:_____

SIGNATURES

Patient / Parent / Legal Guardian / Personal Representative Signature: _____

Printed Name: _____ Date: _____

Witness (Optional) Signature: _____

Printed Name: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

LAKESIDE DENTAL
FAMILY & COSMETIC DENTISTRY

Effective Date: July 29, 2026

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This Notice describes how Lakeside Dental may use and disclose your Protected Health Information (PHI), your privacy rights, and our legal responsibilities. Please read it carefully.

Protected health information includes information that identifies you and relates to your past, present, or future physical or dental health, the healthcare services you receive, or payment for those services.

YOUR RIGHTS

You have the following rights regarding your protected health information:

- Inspect or obtain a paper or electronic copy of your dental and medical records.
- Request that we correct information you believe is inaccurate or incomplete.
- Request confidential communications (for example, calling only your cell phone or sending mail to a different address).
- Request restrictions on how we use or disclose your information.
- Request an accounting of certain disclosures of your health information.
- Receive a paper copy of this Notice at any time.
- Choose someone legally authorized to act on your behalf.
- File a complaint if you believe your privacy rights have been violated.

Access to Your Records

Your records may include clinical notes, treatment plans, dental charts, radiographs, CBCT images, intraoral and extraoral photographs, prescriptions, billing records, insurance information, and other health information maintained by our practice.

Paying Out of Pocket

If you pay for a service in full out of pocket, you may request that we not disclose information about that service to your health plan for payment or healthcare operations. We will honor that request unless disclosure is required by law.

HOW WE MAY USE OR DISCLOSE YOUR INFORMATION

Treatment

We may use and disclose your information to provide, coordinate, and manage your dental care. This may include communicating with physicians, specialists, pharmacies, dental laboratories, and other healthcare providers involved in your treatment.

Payment

We may use your information to bill and collect payment for services provided. This may include communicating with insurance companies, financing companies, payment processors, or collection agencies as permitted by law.

Healthcare Operations

We may use your information to operate and improve our practice. Examples include quality improvement, staff training, licensing, accreditation, compliance activities, auditing, risk management, customer service, and business planning.

Business Associates

We may share your information with trusted companies that perform services for our practice, such as electronic records, imaging, billing, information technology, or payment processing. These companies are required by law and contract to safeguard your information.

OTHER PERMITTED OR REQUIRED DISCLOSURES

Federal and state law permit or require us to disclose health information in certain situations, including:

- Public health activities ● Reporting abuse, neglect, or domestic violence ● Health oversight agencies
- Judicial or administrative proceedings ● Law enforcement ● Workers' compensation ●
- Medical examiners or funeral directors ● Organ and tissue donation ● Military or national security purposes
- Research when permitted by law ● To prevent or lessen a serious threat to health or safety

We will disclose only the information necessary and only when permitted or required by law.

YOUR CHOICES

You may tell us whether we may share information with:

- Family members ● Friends ● Caregivers
- Individuals involved in your healthcare ● Individuals involved in paying for your care

If you are unable to tell us your wishes, we may share information when, in our professional judgment, doing so is in your best interest or necessary to prevent a serious threat to health or safety.

Being authorized to receive information does not authorize someone to make healthcare decisions for you unless they have separate legal authority.

COMMUNICATIONS

We may contact you regarding:

- Appointment reminders ● Appointment confirmations ● Follow-up care ● Preventive care
- Treatment recommendations ● Prescription information ● Insurance matters ● Billing and payment

Depending on your preferences, we may contact you by:

- Telephone ● Voicemail ● Text message ● Email ● Postal mail

Standard text messaging and email are not encrypted and may not be completely secure. If you prefer that we not communicate with you by these methods, please let us know.

SPECIAL PROTECTIONS

Certain categories of information receive additional protection under federal or state law, including, when applicable:

- Substance use disorder treatment records
- Psychotherapy notes
- Mental health information
- HIV-related information
- Genetic information
- Reproductive health information
- Information relating to minors

If Lakeside Dental receives records protected by 42 CFR Part 2, those records generally may not be used or disclosed in civil, criminal, administrative, or legislative proceedings without your written consent or another authorization required by law.

When state law provides greater privacy protection than HIPAA, we will follow the law providing the greater protection.

USES REQUIRING YOUR WRITTEN AUTHORIZATION

Except as described in this Notice or otherwise permitted by law, we will obtain your written authorization before using or disclosing your health information.
This includes, when required by law:

- Most marketing uses
- Sale of protected health information
- Most disclosures of psychotherapy notes
- Certain specially protected records

You may revoke your authorization at any time in writing. Revocation will not affect actions already taken in reliance on your authorization.

OUR RESPONSIBILITIES

Lakeside Dental is required by law to:

- Maintain the privacy and security of your protected health information.
- Provide you with this Notice.
- Follow the terms of the Notice currently in effect.
- Notify you if a breach occurs that may have compromised your protected health information.
- Comply with applicable federal and state privacy laws.

We reserve the right to revise this Notice at any time. The revised Notice will apply to all protected health information we maintain and will be available in our office and on our website. A current copy of this Notice is always available at our office and at **www.mylakesidedental.com.**

QUESTIONS OR COMPLAINTS

If you have questions about this Notice, wish to exercise your privacy rights, or would like to file a complaint, please contact:

Privacy Officer: Dr. Keith Egan
Lakeside Dental
1011 Catherine Street
Salt Lake City, Utah 84116
Phone: (801) 596-3000
Email: office@mylakesidedental.com
Website: www.mylakesidedental.com

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

Lakeside Dental will not retaliate against you for exercising your privacy rights or filing a complaint.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

LAKESIDE DENTAL
FAMILY & COSMETIC DENTISTRY

Patient Name: _____ **Date of Birth**: _____

Lakeside Dental's **Notice of Privacy Practices** explains how we may use and disclose your protected health information, your rights regarding that information, and our responsibilities for protecting your privacy.

By signing below, I acknowledge that Lakeside Dental has provided me with, or made available to me, a copy of its Notice of Privacy Practices.

I understand that:

- I may request a paper copy of the Notice at any time, even if I received or reviewed it electronically.
- I may ask questions about the Notice or about how my health information is used or disclosed.
- Signing this acknowledgment confirms that I received or was given access to the Notice. It does not authorize uses or disclosures beyond those permitted or required by law.
- Lakeside Dental may revise its Notice of Privacy Practices. The current Notice will be available at the office and on the practice website.
- I may request restrictions on certain uses or disclosures of my health information, although Lakeside Dental may not be required to agree to every request.

The **HIPAA Privacy Rule** requires a dental practice with a direct treatment relationship to provide its Notice no later than the first service delivery and make a good-faith effort to obtain written acknowledgment. A patient's refusal to sign does not prevent the practice from using or disclosing health information as otherwise permitted by HIPAA.

PATIENT ACKNOWLEDGMENT

I acknowledge that I have received, or have been given access to, Lakeside Dental's Notice of Privacy Practices.

Patient's Signature: _____ Date: _____

PERSONAL REPRESENTATIVE

Complete this section only when someone is signing for the patient.

Name of Personal Representative: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Healthcare Agent ☐ Other: _____

Authority to Act for Patient, if applicable:_____

Personal Representative's Signature: _____ Date: _____

PRIVACY CONTACT

Questions, concerns, requests for copies, or privacy complaints may be directed to:

Privacy Contact: Dr. Keith Egan
Lakeside Dental
1011 Catherine Street
Salt Lake City, Utah 84116
Telephone: (801) 596-3000
Website: www.mylakesidedental.com

FOR OFFICE USE ONLY

Lakeside Dental made a **good-faith effort** to provide the Notice of Privacy Practices and obtain written acknowledgment, but the acknowledgment was not obtained because:

☐ Patient declined to sign ☐ Patient was unable to sign ☐ Personal representative was unavailable
☐ Emergency treatment circumstances ☐ Communication or language barrier
☐ Notice was provided electronically, but acknowledgment was not returned ☐ Other: _____

Notice provided or made available by:

☐ Paper copy ☐ Electronic copy ☐ Practice website ☐ Other: _____

Staff Member: _____ Date: _____

Additional Notes:_____
_____
_____
_____

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

LAKESIDE DENTAL
FAMILY & COSMETIC DENTISTRY

I authorize Lakeside Dental to discuss my protected health information, including appointment information, treatment recommendations, insurance, billing, and payment information, with the individual(s) listed below.

Authorized Individual: _____

Relationship to Patient: _____

Phone Number (Optional): _____

Authorized Individual: _____

Relationship to Patient: _____

Phone Number (Optional): _____

Authorized Individual: _____

Relationship to Patient: _____

Phone Number (Optional): _____

This authorization does not permit the authorized individual to make healthcare decisions for me unless that individual has separate legal authority to do so.

☐ I understand that this authorization is voluntary and may be revoked at any time by providing written notice to Lakeside Dental. This authorization will remain in effect until I revoke it in writing.

Patient Signature: _____ Date: _____

☐ I do **NOT** authorize Lakeside Dental to discuss my protected health information with anyone other than myself, unless otherwise permitted or required by law.

GENERAL CONSENT TO TREATMENT

LAKESIDE DENTAL
FAMILY & COSMETIC DENTISTRY

GENERAL CONSENT TO DENTAL TREATMENT

I voluntarily consent to receive dental examination, diagnosis, and treatment from Dr. Keith Egan, DDS, Lakeside Dental, and any licensed dentists, hygienists, assistants, or other authorized clinical staff participating in my care.
I authorize the dental team to perform routine dental services that are considered necessary or advisable for my diagnosis, treatment, and ongoing oral health care, including, when appropriate:

- Comprehensive and limited examinations ● Dental cleanings and preventive care ● Periodontal evaluations
- Dental radiographs (X-rays), photographs, and digital imaging, including CBCT when clinically indicated
- Diagnostic tests ● Fluoride treatments ● Sealants ● Local anesthesia
- Nitrous oxide (when separately authorized, if applicable) ● Placement of temporary restorations or sedative dressings
- Routine restorative procedures ● Emergency treatment necessary to relieve pain, control infection, or prevent further injury

I understand that additional treatment recommendations may be made after my examination or as treatment progresses.

RISKS OF DENTAL TREATMENT

I understand that all dental procedures involve some degree of risk and that complications cannot always be predicted.
Possible risks may include, but are not limited to:

- Temporary or prolonged discomfort ● Swelling ● Bruising ● Bleeding ● Infection ● Tooth sensitivity
- Temporary difficulty chewing ● Jaw muscle soreness or fatigue
- Aggravation of temporomandibular joint (TMJ) symptoms
- Allergic or adverse reactions to medications or dental materials
- Temporary or, in rare cases, permanent numbness associated with local anesthesia
- Accidental injury to the lips, tongue, cheeks, or surrounding tissues
- Breakage of instruments or dental materials
- Swallowing or aspiration of small dental instruments or materials, which may require additional medical evaluation or treatment

Although uncommon, unforeseen conditions may be discovered during treatment that require changes to the planned procedure or additional treatment.

MEDICATIONS AND MEDICAL HISTORY

I understand the importance of providing complete and accurate medical information, including:

- Current medications
- Allergies
- Medical conditions
- Previous surgeries
- Pregnancy status, when applicable

I agree to notify Lakeside Dental of any changes to my health or medications.
I understand that certain medications, including bisphosphonates and other medications used to treat osteoporosis or certain cancers, may increase the risk of complications following oral surgery or tooth extractions.

NO GUARANTEE

I understand that dentistry is not an exact science. Although every reasonable effort will be made to achieve a successful result, no guarantee, warranty, or assurance has been made regarding the outcome or longevity of any treatment.

PROCEDURE-SPECIFIC CONSENT

I understand that certain procedures—including, but not limited to, dental implants, extractions, root canal therapy, periodontal surgery, intravenous or oral sedation, and other complex treatments—may require separate informed consent forms describing the specific risks, benefits, alternatives, and expected outcomes.

QUESTIONS

I certify that:

- I have had the opportunity to ask questions. ● My questions have been answered to my satisfaction.
- I understand the information provided. ● I voluntarily consent to the recommended examination and treatment.

PATIENT INFORMATION

Patient Name (Print):_____

Name of Parent, Legal Guardian, or Personal Representative if applicable :_____

Relationship to Patient:_____

SIGNATURES

Patient / Parent / Legal Guardian / Personal Representative
Signature: _____ Printed Name: _____Date: _____

Witness (Optional)
Signature: _____ Printed Name: _____Date: _____