Stacey Gividen, DDS – Justin Simmons, DDS – 710 N. 1st Street, Hamilton MT 59840 – (406) 375-1192

Patient's First Name: _____ **Last Name:** _____ **Today's Date:** _____

General Patient Consent

I agree to be a patient at canyon View Dental, with Drs. Justin Simmons and/or Stacey Gividen. I consent to, understand, and agree to the following:

- Complete clinical examination which may/may not include: radiographic imaging, intraoral or extraoral photos, and diagnostic casts.
- During the course of treatment I may undergo procedres in all phases of dentistry including but not limited to: periodontics (gum treatments and surgery), oral surgery procedures, endodontics, fixed and removable prosthetics (crowns, bridges, dentures), restorative implant dentistry, restorative dentistry (fillings), oral pathology, pedatrics, and radiography.
- I will provide a thorough and complete medical history, supply a listing of medications, and consent to my dentist consulting with other medical practitioners to inquire about any aspect of my medical history and/or treatments.
- No guarantees have been made about treatment outcomes, restorative longevity, or prognosis. I understand that all medicine, including dentistry, can involve unanticipated results.
- I will pay in full all cost of treatment or insurance co-payments at the time of service according to the offices financial policy which I will be given. I am ultimately responsible for all costs associated with treatment and although the staff will do their best to help estimate my portion of treatment costs, I am responsible for knowing what my insurance will/will not contribute.
- My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental staff.
- I am always welcome to ask questions about my dental care, and I am responsible for clarifying any aspect that I am unsure about.

Patient or Representative Signature: _____ Date: _____

Relationship to patient: _____

Acknowledgement of Reciept of Notice of Privacy Practices

I have had the opportunity to read and understand Canyon View Dental's Notice of Privacy Practices written in plain language. (A copy of the notice will be furnished upon my request and is available on the practice's website.) The notice provides in detail the uses and disclosures of my protected health informtion that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me an opportunity to review the revised notice upon request.

Patient Name :_____ Date: _____

Patient or Representative Signature: _____ Date: _____

Relationship to patient: _____

For office Use:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented obtainment
- ☐ Other: _____