Acknowledgement of Receipt of Notice of Privacy Practices
Office of Dr Jeffrey S Meral
* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____ Signature_____

Date:_____

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Agreement to Receive/ Send Electronic Communication

Patient Name: _____
Date of Birth:_____

I agree that the Dental practice can send x-rays and treatment information to a Dental Specialist/Dental Office that I request and/or be sent to an office that I am currently being treated by.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I can withdraw my consent to electronic communications by calling 954-755-8100.

Patient Signature:_____

Date:_____

JEFFREY S. MERAL, DDS, PA

10233 W. Sample Road • Coral Springs, FL 33065
(954) 755-8100

Family Dentistry

CONSENT TO PERFORM DENTISTRY

1. EXAMINATION:

I hereby authorize Dr. Jeffrey S. Meral and or his dental auxiliaries to exam my dental condition and make the necessary treatment recommendations.

2. RISK:

I understand that with any medical or dental treatment there are risks that are associated with treatment.

3. TREATMENT PLAN:

I understand that during treatment it may be necessary to add or change a procedure because of conditions found while working on the teeth that were not discovered during examination. Example: Root Canal, following large fillings, or fractures found inside of a tooth. These additional or different procedures will be discussed before continuing with such treatment.

4. ANESTHESIA:

I understand that there are possible risks and complications associated with the administration of local anesthesia, nitrous oxide, and prescription drugs. These range from Common: such as soreness, bruising, and rapid beating of the heart, lip and cheek biting. Infrequent: such as allergic reactions, fainting. To extremely rare: such as swelling, bleeding, pain, nausea, vomiting, permanent tingling and numbness of the lips, gums, face and tongue, hematoma (swelling or bleeding at or near the injection site), coma, or death. I understand and have been informed of the risk and complications.

5. FOLLOW UP:

I understand that the success of the dental treatment to be provided will require that the patient follow post-operative instructions from Dr. Meral. I understand that the success of the treatment requires that all post-operative instructions be followed and regular office visits as scheduled by Dr. Meral and his auxiliaries must be maintained.

6. FILLINGS:

I understand that care must be exercised in chewing on filled teeth, especially during the first 24 hours to avoid breakage. I understand that a more extensive restorative procedure that originally diagnosed may be required due to additional or extensive decay, or fracture. I understand that sensitivity is a common after effect of a newly placed filling. I understand that for unknown reasons, after any dental treatment, the nerve of the tooth can die or become hypersensitive, leading to root canal, or even loss of the tooth.

7. CROWNS, BRIDGES, VENEERS:

I understand that sometimes it is not possible to match the color of natural teeth exactly with the artificial teeth. I further understand that I may be wearing temporary crowns, which come off easily and that I must be careful to ensure that they are kept on until the permanent crown is delivered. I realize the final opportunity to make changes (shape of fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be additional charges to remakes due to my delaying permanent cementation. I understand that for unknown reasons, after any dental treatment, the nerve of the tooth can die or become hypersensitive, leading to root canal, or even loss of the tooth.

8. PERIODONTAL DISEASE:

I understand that if I am diagnosed with periodontal disease, that lack of treatment will lead to the loss of my teeth. Alternative periodontal treatments will be explained which will include, gum surgery, tooth extraction and or replacement.

9. PARTIALS AND DENTURES:

I understand the wearing of partials/dentures is difficult. Sore spots, altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extraction's) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed at a later date. This is not included in the dentures fee. I understand that it is my responsibility to return for delivery of my partial/denture. I understand that failure to keep my delivery appointment may result in poorly fitting dentures. If a remake is requires due to my delay of more than 30 days, additional charges could be incurred.

PATIENT OR GUARDIAN SIGNATURE: _____

PATIENTS NAME: _____ **DATE:** _____

(RELATIONSHIP TO PATIENT) _____

SIGNATURE _____ **DATE:** _____

SIGNATURE _____ **DATE:** _____

SIGNATURE _____ **DATE:** _____

SIGNATURE _____ **DATE:** _____

SIGNATURE _____ **DATE:** _____