Howe Dental Associates
15 Howe Ave, Suite 2B
Passaic, NJ 07055
Tel: 973.365.1931
Fax: 973-365-1590
Email: HoweDentalAssociates@gmail.com
Web: www.howedentalnj.com

Dr.Michael Weiner, D.D.S.
NJ License: 22DI02459000
NPI: 1356648422

General Consent Form

SECTION A: PATIENT INFORMATION

Patient Name:_____

Date of Birth_____

SSN:_____

SECTION B: CONSENT TO TREATMENT

I do hereby authorize and request the performance of dental services and the use of whatever procedures Dr. Weiner may deem necessary for treatment. I understand that Dr. Weiner and his staff will use clinical and patient management techniques that are reasonable, necessary, and advisable. I also authorize the administration of anesthetics or analgesics that may deem appropriate by Dr. Weiner. I understand that the purpose for using local anesthetics may be therapeutic, diagnostic, or for the treatment of facial pain. I understand that potential complications include, but are not limited to pain, swelling, bruising, temporary limited opening, and local infection. I understand that in occasional cases the anesthesia may be prolonged and in very rare cases permanent.

I understand that I am responsible for attaining any current x-rays that may have been taken at a previous office. If I do not obtain them, I permit the retaking of any necessary x-rays. I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since the examination and extend of dental pathology. Occasionally, once the treatment plan has been started, complications may arise that dictate additional procedures or treatment. Dr. Weiner, or his staff will always advise me of any changes.

In the event that Dr. Weiner , or his staff member is exposed to my blood or other bodily fluids, I agree to have my blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C virus (HCV), and the human immunodeficiency (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and the person would be advised of his/her rights regarding protected health information.

SECTION C: SIGNATURE:

Printed Patient/Guardian Name: _____

For Guardians, please note your relationship to patient:_____

Date: _____