# 2022 OFFICE UPDATES

## PLEASE READ AND SIGN ALL PAGES

We are currently updating paperwork for 2022. We require new paperwork ONCE a year.

In addition, if your insurance has changed, please provide a copy of your new insurance card as soon as you receive it. If your insurance hasn't changed, we will still need a copy of your card for the new calendar year (2022). We will run eligibility and benefits to determine the projected estimated cost and coverage for work that you may need in 2022.

**NAME:**_____

**ADDRESS:**_____

_____

_____

**PHONE#:**_____ ☐ **CELL** ☐ **HOME** ☐ **WORK**

**ALTERNATE PHONE #:**_____ ☐ **CELL** ☐ **HOME** ☐ **WORK**

**EMAIL:**_____

**INSURANCE CARRIER:**_____

****STATE LAW REQUIRES THAT WE OBTAIN YOUR CONSENT FOR TREATMENT.THERE ARE RISKS ASSOCIATED WITH ANY DENTAL TREATMENT. THESE INCLUDE, BUT ARE NOT LIMITED TO: INFECTION, BLEEDING, FAILURE OF WOUND TO HEAL, INJURIES TO ADJACENT TEETH OR STRUCTURES, INCOMPLETE REMOVAL OF TOOTH, DRY SOCKET, LOSS OF TEETH, LOSS OF BONE, INSTRUMENT BREAKAGE, BREAKAGE OF ROOTS, TREATMENT OF WRONG TOOTH, RETAINED ROOT FRAGMENTS, SWALLOWING OF OBJECTS, ALLERGIC REACTIONS TO DRUGS, JAW PAIN, PAIN IN OPENING MOUTH, FAILURE OF TREATMENT TO ACCOMPLISH ITS PURPOSE, NUMBNESS OF TONGUE AND MOUTH, DEATH, AND BACTERIAL ENDOCARDITIC. I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE INFORMATION ON THIS FORM. I HEREBY AUTHORIZE THE DENTIST, HYGIENIST, AND ASSISTANTS OF THEIR CHOICE TO PERFORM DIAGNOSITC, SURGICAL, AND DENTAL TREATMENT. FURTHERMORE, IF I HAVE INSURANCE COVERAGE, I AUTHORIZE RELEASE OF INFORMATION RELATING TO INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COST OF DENTAL TREATMENT. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO TWIN OAKS DENTAL STUDIO OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.****

**PATIENT OR GUARANTOR SIGNATURE:**_____ **DATE:**_____

TWIN OAKS
DENTAL STUDIO