RECERTIFICATION AND CONTINUING CONSENT FOR TREATMENT FORM

Print Full Legal Name of Patient : _____

Does Patient have a **COURT APPOINTED** Legal Guardian (LG) or **ACTIVATED** Power of Attorney (POA) ? YES NO

If Yes, The LG/POA contact info is required and the COURT APPOINTED (LG) or Activated (POA) will need to sign all forms :
Legal Guardian (LG)/Power of Attorney (POA) info :

(Name) _____

(Phone #) _____(Address)_____

Facebook : We use this information only to send friend requests to our patients. Most of our patients like to be in contact with our office thru Facebook. If you do not wish to give out this information - No Worries - we understand.

Facebook User ? YES NO
Facebook Name : _____

I, the patient/parent/guardian/POA, certify that there have been no changes in the above named patient's medical history, dental history, registration information, general information, dental insurance, or any other applicable information, except as noted below. I, the patient/parent/guardian/POA, certify the patient has not stopped, started, or changed any prescription or over-the-counter (OTC) medications, except as noted below. I, the patient/parent/guardian/POA, certify the patient has not suffered any illnesses or injuries since the patient's last visit, except as noted below. I, the patient/parent/guardian/POA, certify all medical treatments or consultations the patient has had since their last visit has been listed below. I, the patient/parent/guardian/POA, will not hold Dr. James J. Herget or his employees responsible for any errors or omissions that may have been made in completion of this form. I, the patient/parent/guardian/POA, hereby authorize Dr. James J. Herget and whomever he designates as his dental hygienists and assistants to perform dental treatment on the above named patient. I, the patient/parent/guardian/POA, give my continuing consent to all advisable and necessary dental procedures needed for diagnostic purposes and dental treatment. I, the patient/parent/guardian/POA, further consent to the administration of local anesthetics, antibiotics, analgesics, or any other drugs that may be deemed necessary by Dr. James J. Herget. I, the patient/parent/guardian/POA agree Dr. Herget will not be held responsible for any sub-standard treatment or complications from treatment done by another provider such as, but not all inclusive : Oral Surgeon/Endodontist/Orthodontist/Pedodontist/TMJ specialist/Prosthodontist/Periodontist/Radiologist/Pathologist/General Dentist/Physician/etc. I, the patient/parent/guardian/POA understand that female patients taking birth control pills need to find an additional method of birth control should Dr. Herget prescribe antibiotics, as the antibiotic may inactivate the birth control pills effectiveness. It is recommended these patients contact their physician regarding this matter.

Changes & Updates :

I, the patient/parent/legal guardian (LG)/power of attorney (POA), certify that the answers given to the questions asked in this **Recertification and Continuing Consent for Treatment Form** are correct and the information is complete and accurate. I, the patient/parent/LG/POA, will not hold Dr. James J. Herget or his employees responsible for any errors or omissions made by the patient/parent/LG/POA during the completion of this form. If patient/parent/LG/POA does not comprehend the English language, it is agreed a translator has been used so patient/parent/LG/POA could understand and consent to this form.

Patient Signature (**Adult** patients only) _____ Date _____

Parent Signature (**Minor** patients only) _____ Date _____

Power of Attorney/Legal Guardian Signature (if applicable)_____ Date _____

Translator Signature (if applicable)_____ Date _____

Translator Name (PRINT) _____