Patient's Full Legal Name _____**Patient** Birth Date : _____

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)_____

Patient's Physician Name _____Physician's Phone # _____

Physician's Address _____

Patient's Pharmacy and City of Pharmacy _____

Does patient's physician advise patient take **Antibiotics** before dental appointments ? YES NO

Is patient taking any **Bisphosphonate** drugs (usually taken to treat Osteoporosis) ? YES NO
(ex : Fosamax, Boniva, Actonel, Skelid, Didronel, Aredia, Zometa, Reclast, Aclasta, Atelvia, Binosto etc.)

Is patient taking **Blood Thinners** ? YES NO
(ex : Coumadin, Warfarin, Pradaxa, Xarelto, Lovenox, Eliquis, Arixtra, Heparin etc.)

Has patient ever had an **Allergic Reaction** to any of the following ? (**Circle all that apply**)

PENICILLIN CEPHALEXIN CLINDAMYCIN AZITHROMYCIN CODEINE OXYCODONE (Percocet)

ACETAMINOPHEN (Tylenol) IBUPROFEN (Advil) NAPROXEN (Aleve) HYDROCODONE (Vicodin - Norco)

List all other drug allergies patient may have :

CIRCLE any of the following conditions patient has had in the past (or) may have at the present :

Prosthetic Heart Valve
Heart Valve Repair
History of Endocarditis
Heart Transplant
Congenital Heart Defect
Heart Pacemaker
Artificial Joint
Psychiatric Treatment
Weakened Immune System
Donor Organ Recipient
AIDS and/or HIV Positive
Chemotherapy
Radiation Treatment
Alcoholism
Drug Addiction
Hepatitis B or C

Does patient have any other disease, condition, or medical problem not listed above ? Is there anything else we should know about the patient's health that has not been covered in this form ? YES NO If Yes, explain below, use back if needed :

I, the patient/parent/legal guardian (LG)/power of attorney (POA), certify that the answers given to the questions asked in this **Medical History 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) _____

Print Only – Ink Only – Circle Correct Answers

Print Patient's Full Name : _____

Is patient taking any Illegal drugs ? YES NO If, yes list drug(s) :

Is patient taking any prescription, OTC (over the counter), or herbal medications ? YES (List Below) NO

Drug or Medication Name	Dosage	Frequency of Use	Reason for Taking Drug or Medication
Example : Atenolol	Example : 100 mg	Example : Twice per day	Example : High Blood Pressure

I, the patient/parent/legal guardian (LG)/power of attorney (POA), certify that the answers given to the questions asked in this **Patient Medication 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) _____

Print Only – Ink Only

Print Patient's Full Name :_____

I, the patient/parent/guardian/POA, hereby authorize Dr. James J. Herget dba James J. Herget DDS LLC dba Affiliated Dentistry of Mayville and whomever he designates as his dental hygienists and dental assistants to perform dental treatment on the above named patient. I, the patient/parent/guardian/POA, give my consent to all advisable and necessary dental procedures and x-rays (radiographs) 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 drug that may be deemed necessary by Dr. Herget. I, the patient/parent/guardian/POA, give consent to Dr. James J. Herget to use at his discretion any dental material he feels is in the best interest of the patient. Should the above named patient or their parent/guardian/POA want a specific dental material placed by Dr. Herget, the request must be made in writing prior to treatment. Dr. Herget reserves the right to refuse treatment if the request for the dental material, is in his opinion, not in the best interest of the patient. I, the patient/parent/guardian/POA, understand Dr. James J. Herget has the right to refuse treatment to anyone who refuses digital x-rays.

I, the patient/parent/guardian/POA, understand that there is an element of risk which occurs during any dental procedure and during the administration of any drug or anesthetic. I have been informed and fully understand in any type of dental procedure there may be unavoidable complications of the treatment. Possible complications may be as follows (this list is not all inclusive) :

General Dentistry : Soreness, nausea, vomiting, pain, swelling, bruising, restricted opening of the mouth, jaw joint (TMJ) discomfort or stiff jaws, bleeding, adverse drug reactions such as an allergic reaction to anesthetics and post-operative medications, infection, stretching or cracking at the corners of the mouth, etc.

Tooth Extractions : Delayed healing "Dry Socket", damage to adjacent teeth/fillings/crowns, soft tissue damage, bone splinters/sharp ridges, Portions of tooth remaining : sometimes root tips break and may be deliberately left in place to avoid damage to nearby vital structures such as nerves or the sinus cavity, Sinus infection and/or sinus opening may result with upper back teeth > this may require additional procedures to correct, jaw fracture, loss of additional teeth, general numbness, aspiration or swallowing of fillings, crowns, tooth, or bone fragments etc.

Local Anesthesia : Swelling/irritation at the injection site(s), damage to tongue and/or lips from patient biting while numb, irritation to veins, arteries, or nerves; Numbness : the lips, chin, teeth, gums, and/or tongue may have a continuous numb feeling; there may also be a loss of taste and/or change is speech; The numbness may remain for a few days, weeks, months, or become permanent etc.

I, the patient/parent/guardian/POA, also understand recent studies have shown instances of patients taking bisphosphonate drugs (usually taking to treat osteoporosis) such as Fosamax and Boniva, may develop a condition known as osteonecrosis - deterioration of the jaw. I, the patient/parent/guardian/POA release Dr. Herget and his staff from all liability should this rare condition occur after receiving routine dental treatment. I, the patient/parent/guardian/POA, understand and acknowledge any medical or dental procedure has risks and am aware that the practice of dentistry is not an exact science. I, the patient/parent/guardian/POA, acknowledge that no guarantees have been made concerning the results of treatment and hereby request dental services from Dr. James J. Herget and his employees. I, the patient/parent/guardian/POA understand this consent is to be continuing in nature unless revoked in writing by the patient/parent/guardian/POA.

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. If patient does not comprehend the English language, it is agreed a translator has been used so patient could understand and consent to this form. 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/legal guardian (LG)/power of attorney (POA), certify that the answers given to the questions asked in this **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) _____

Continuing Financial Agreement And Consent Form (page 4)

Print Only – Ink Only

Print Patient's Full Name :_____

If the patient/parent/guardian/POA has dental insurance, we will assist the patient/parent/guardian/POA in receiving their maximum allowable benefits. In order to achieve this goal, we need the assistance, cooperation, and understanding of the patient/parent/guardian/POA regarding our payment policy. We will gladly discuss any proposed treatment and answer any questions related to dental insurance. However, realize the following :

1. Our fees are very competitive and range very close to national averages. Our fees are considered acceptable, usual, customary, and reasonable by almost all insurance companies.

2. Not all services are covered benefits by all insurance companies. It is the patient/parent/guardian/POA's responsibility to keep track of deductibles and yearly maximums. We do not keep track of that type of information.

3. All charges are the responsibility of the patient/parent/guardian/POA, even if the insurance company pays or approves only a portion of the charges.

If the patient/parent/guardian/POA does not have dental insurance, payment for service is due, in full, at the time the services are rendered. We accept cash, money orders, checks, MASTERCARD, VISA, DISCOVER etc. We will be happy to help process all insurance claims no charge. This financial agreement is to be continuing in nature unless revoked in writing by the patient/parent/guardian/POA.

I, the patient/parent/guardian/POA, hereby authorize payment to Dr. James J. Herget of the dental insurance benefits otherwise payable to me. This "Signature on File" is valid from the below date until a written and dated statement of revocation is received by Dr. James J. Herget. I, the patient/parent/guardian/POA, authorize Dr. James J. Herget or his employees to provide any insurance company or claim administrator information concerning the dental care of the patient in order to assist in the processing of all dental insurance claims.

I, the patient/parent/guardian/POA, certify I have read the above information. I, the patient/parent/guardian/POA, have had all questions answered regarding this information, and agree to honor and abide by the above stated policy. I, the patient/parent/guardian/POA, understand payment is due as services are rendered unless prior arrangements are made. I, the patient/parent/guardian/POA, understand any unpaid insurance balances are my responsibility. The undersigned also agrees to be financially responsible for all charges incurred for the above named patient. This agreement is to be continuing in nature unless revoked in writing by the undersigned.

The above named patient and their responsible party such as parent/guardian/POA (if applicable) agree to settle any claim or controversy arising out of or relating to this agreement or services rendered by Dr. James J. Herget and/or his employees by binding arbitration should Dr. James J. Herget request binding arbitration. Should binding arbitration be requested by Dr. James J. Herget, the arbitration shall be conducted in the State of Wisconsin, the arbitrator will be selected by Dr. James J. Herget, and not be consolidated with any claim or controversy of any other party. Also, the patient/parent/guardian/POA understands and agrees Dr. James J. Herget may seek interim or preliminary relief to protect the rights or property of Dr. James J. Herget and/or his employees pending the completion of any arbitration process, if such a process is requested by Dr. Herget. The patient/parent/guardian/POA also understand and agree Dr. James J. Herget also has the right not to use binding arbitration at his discretion.

I, the patient/parent/legal guardian (LG)/power of attorney (POA), certify that the answers given to the questions asked in this **Continuing Financial Agreement and Consent 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) _____