CONSENT FOR TREATMENT:

THIS INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD THE DENTIST OR ANY STAFF MEMBER RESPONSIBLE FOR ERRORS/OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM. MY SIGNATURE BELOW GIVES CONSENT FOR THE DENTIST AND EMPLOYEE OF PREMIER DENTAL GROUP, PLLC OF KNOXVILLE TO PERFORM ANY NECESSARY DENTAL PROCEDURES.

_____ _____

PATIENT/PARENT/GUARDIAN SIGNATURE **DATE**

CONSENT FOR NITROUS OXIDE:

I GIVE MY CONSENT FOR THE USE OF NITROUS OXIDE/OXYGEN (laughing gas/happy air) AS DEEMED APPROPRIATE BY THE DENTIST AT PREMIER DENTAL GROUP, PLLC OF KNOXVILLE TO HELP CONTROL ANXIETY FOR MYSELF OR MY CHILD DURING TREATMENT.

I HAVE BEEN INFORMED THAT THE NITROUS OXIDE/OXYGEN MAY MAKE MY CHILD OR MYSELF "TINGLY" OR "FLOATY" AND THAT THE NITROUS OXIDE WILL BE COMPLETELY DISSIPATED FROM THE PATIENT'S SYSTEM AFTER 2 OR 3 MINUTES OF BREATHING ROOM AIR. I ALSO UNDERSTAND THAT, WHILE IT RARELY OCCURS NAUSEA IS A POSSIBLE ADVERSE AFFECT OF THE NITROUS OXIDE.

_____ _____

PATIENT/PARENT/GUARDIAN SIGNATURE **DATE**

ACKNOWLEDGEMENT OF RECEIPT:

I HAVE RECEIVED A COPY OF PREMIER DENTAL GROUP, PLLC O KNOXVILLE "NOTICE OF PRIVACY PRACTICE" THAT BECAME EFFECTIVE APRIL 14, 2003.

_____ _____

PATIENT/PARENT/GUARDIAN SIGNATURE **DATE**

FEES & PAYMENTS

WE MAKE EVERY EFFORT TO KEEP DOWN THE COST OF YOUR CARE. YOU CAN HELP US BY PAYING UPON COMPLETION OF EACH VISIT. YOU UNDERSTAND THAT EVEN THOUGH YOU HAVE SOME TYPE OF INSURANCE COVERAGE, YOU ARE FULLY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED. YOU ALSO AGREE TO PAY ALL COSTS INCIDENT TO COLLECTION, INCLUDING ATTORNEY'S FEES.

INSURANCE:

PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST. WE ARE HAPPY TO FILE THE FORMS NECESSARY TO SEE THAT YOU RECEIVE THE ESTIMATED COVERAGE. AN INSURANCE POLICY IS AND AGREEMENT BETWEEN YOU AND THE INSURANCE COMPANY, THEREFORE, THE INSURED WILL BE DIRECTLY RESPONSIBLE FOR ALL CHARGES. IF FOR SOME REASON YOUR INSURANCE COMPANY HAS NOT PAID THEIR PORTION WITHIN 60 DAYS FROM THE START OF TREATMENT, YOU ARE RESPONSIBLE FOR THE ENTIRE PAYMENT AT THAT TIME. THE PATIENT IS RESPONSIBLE FOR NOTIFYING OUR OFFICE OF ANY CHANGES IN INSURANCE COVERAGE.

I, HEREBY AUTHORIZE THE RELEASE OF ANY DENTAL INFORMATION NECESSARY FOR THE PROCESSING OF INSURANCE. I ALSO ASSIGN ALL INSURANCE BENEFITS TO PREMIER DENTAL GROUP, PLLC OF KNOXVILLE.

_____ _____

PATIENT/PARENT/GUARDIAN SIGNATURE **DATE**

SIGNATURES ABOVE HAVE BEEN WITNESSED BY _____, A MEMBER OF PREMIER DENTAL

GROUP, PLLC of KNOXVILLE ON THIS DATE _____