



Consent for Exam

Date: _____

Name: _____

I, _____, give Dr. Timothy J. Huff and his team my permission to make the necessary radiographs (x-rays), photographs, periodontal (gum) measurements and plaque specimen, charting of existing restorations, diagnostic casts (models of teeth), and bite records to provide data for the assessment of my dental health. Furthermore, I authorize Dr. Huff to conduct a complete exam of my dental condition including, but not limited to:

- *American Cancer Society Head/Neck, (intra/extra oral) cancer screening
- *TMJ evaluation
- *Periodontal evaluation
- *Complete inventory of existing restorations
- *Radiographic evaluation of oral/head/neck structures as needed
- *Evaluation of occlusion of teeth (how they come together)
- *Evaluation of dento/facial esthetics using photographs as needed
- *The development of a personalized life-long plan for dental health

Estimated Fees for Exam:

- PARQ** : All **P**rocedures (including no treatment), **A**lternatives and **R**isks have been explained to me and I have had all my **Q**uestions answered to my satisfaction. I knowingly agree with the chosen treatment and will abide by my chosen method of payment.

Method of payment and payment due date: _____

Signed: _____ Date: _____

Informed Refusal of Exam

I, _____, have been informed of the need for a complete dental examination to fully assess my dental needs. I choose to forego this examination at this time and do not hold Dr. Timothy J. Huff responsible for any ramifications due to my refusal of this service.

I do give Dr. Huff permission to perform a problem focused exam limited to the evaluation of:

Due to the limited nature of this exam, I understand that Dr. Huff is not responsible for any other conditions or problems related to my dental health.

Signed: _____ Date: _____