{Dr. Jeff Beasley, DMD}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ______________________ E-mail: ______________________

Patient Number: ______________________ Social Security Number: ______________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Jeff Beasley, DMD

Telephone: (334)793-5697 Fax: (334)793-9521

E-mail: jeffbeasleydmd@graceba.net

Address: 2019 W. Main Street, Dothan, AL 36301

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ______________________________ Date: ______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

The 3rd District Dental Society
of S.E. Alabama Consent form for the use of
Nitrous Oxide and Oxygen (Inhalation Gas)

The gas (nitrous oxide and oxygen) can be very beneficial and is very much used today in dentistry. It can help the patient reduce anxiety and can cause the patient to be more comfortable during dental treatment. Most of the time, the use of gas is complication free; however, there can be some problems with its use which include, but are not limited to:

1) Possible nausea- it is best to not eat before using the gas.
2) Possible sensation of loss of control that some patients experience, and therefore desire the gas to be removed.
3) Possible onset of a headache.
4) Possible hallucinations.

If at any time you want the gas mask removed, please ask any dental assistant or your dentist.

Usually the effects of this gas are completely gone within several minutes after the mask is removed; however, we suggest that someone drive for any patient that uses this gas. If this is not possible, please make sure that the effects of this gas are completely gone before leaving the office.

PATIENT'S STATEMENT of CONSENT

I have read the preceding information. I understand the complications that may occur with the gas. I have had the opportunity to discuss possible complications with my dentist and/or any of the qualified dental assistants or hygienists.

Check one

☐ I do hereby permit my dentist, any qualified dental assistant or hygienist to proceed with the use of nitrous oxide (the gas) along with **MY** dental treatment.

☐ I do hereby permit my dentist, any qualified dental assistant or hygienist to proceed with the use of nitrous oxide (the gas) along with any dental treatment **for my child/dependent.**

☐ I do not wish for nitrous oxide (the gas) to be use on **myself /my child/dependent.**

Patient Name: ______________________________ **DOB:** ____________________

Signed: ______________________________ **Date:** ____________________

Witness: ______________________________ **Date:** ____________________

***The 3rd District Dental Society of S.E. Alabama represents over 100 dentists who are members of the Alabama Dental Association and the American Dental Association.**

Jeff Beasley DMD 2019 West Main Street Dothan, AL 36301 Phone: (334) 793-5697 Fax: (334) 793-9521