

Marsh Lane Dentistry
Stevens Ta D.D.S. & Hanah Nguyen D.D.S.
3628 Frankford Road Ste 235 Dallas, TX 75287 (ph) 972-820-6050 www.tadental.com

Welcome to Our Practice

We are so pleased that you have selected our office for your dental care. Our goals will be to determine what dental treatment you need or want and deliver it in the most efficient manner with clinical excellence and courtesy. We want you to have comfortable, pain free, good looking and functional teeth when you are 95 years old.

Dr. Stevens Ta and Dr. Hanah Nguyen are graduates of Baylor College of Dentistry. Therefore, they both share the same philosophy, techniques and skills. They are constantly update with the newest technology and certified to do some of the latest procedures such as Invisalign, Orthodontic, Cosmetic Dentistry, ZOOM Teeth Whitening. They attended famous dental institution such as Pankey, Dawson, Arrow Head, Straight Wire Orthodontic to update their skills and knowledge.

You can expect to receive the best dental care we can provide. Dental technology has made remarkable strides. You may not be aware of some of the advances in diagnosis and treatment and how they can benefit you. If you have not been to a dentist recently, or have been in the care of someone who has not adopted these techniques, you will notice a difference the first moment you enter our office.

Once you have explained your dental concerns and a thorough dental examination and necessary radiographs have been completed, a treatment plan will be developed. Written explanations of most procedures and problems are available and will be offered to you. Advantages and disadvantages of treatment, risks of treatment or no treatment, options and costs of treatment will be presented. Any questions you have will be answered before treatment begins.

We are committed to providing for each patient an initial appointment during which an exchange of patient concerns and dental desires can be addressed. We respect our patients' time. Unless an unexpected dental emergency arises, we make sure that patients are seen at their scheduled appointment time. We want each patient to feel comfortable, with adequate appointment time to address his or her dental concerns. Please allow adequate travel time to our office.

Cancellation and No-Show Policy

Office hours are by appointment and we do value your time. **Appointment time is reserved just for you alone.** Missed appointments or last minute cancellations leave us with insufficient notice to offer that time to a patient who has been waiting to see us. If you find it is important that our office receive at least 48 hours notice.

Unlike many offices, we understand things happened and we do not charge for the first three (3) broken appointments. However, habitual broken appointments (more than 3 times) may result in a \$25 charge for the time reserved.

Our staff will give you two (2) reminder calls. Please let us know if this becomes inconvenience. **Unless we receive a verbal confirmation from you, we will reserve your appointment time to other patients who has been waiting to see us.**

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Cosmetic & Family Dentistry

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PATIENT'S NAME _____
Last First Initial Date of Birth

I hereby authorize _____
DOCTOR'S NAME

and whomever he/she may designate as his/her assistants, to perform upon me the following operation and/or procedures:

I request and authorize him/her to do whatever he/she deems advisable if any unforeseen condition arises in the course of these designated operations and/or procedures calling, in their judgment, for procedures in addition to or different from those now contemplated.

I consent to the above treatment after having been advised of the risks, advantages and disadvantages of the treatments and the consequences if this treatment were withheld.

I consent to the above treatment plan after having been advised of the alternate plans of treatment available and the known material risks, advantages and disadvantages of the alternative treatment.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration, and thrombophlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my medical condition, contemplated and alternative treatment and procedures, and the risk and potential complications of the contemplated and alternative treatments and procedures, prior to signing this form.

Patient or Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

Witness's Signature _____ Date _____