



**PRE-OPERATIVE INSTRUCTIONS FOR DENTAL SURGERY**

**\*\* VERY IMPORTANT INFORMATION – PLEASE READ CAREFULLY \*\***

**\*\* COMPLETE ATTACHED “MEDICAL HISTORY UPDATE FORM” \*\*  
& RETURN IT TO YOUR DENTIST PRIOR TO SURGERY**

1. We will be reviewing your medical history with you immediately prior to your procedure. Please be sure you are familiar with that information—especially with the name(s) and dosage(s) of any medications you are taking. If you feel your history is relatively complicated, we will need to decide if a consultation with your physician is necessary before the procedure is performed.
2. Unless specified by your dentist, all medicines taken on a routine basis should be continued without interruption. Please swallow with a minimal amount of water.
3. Patients who are minors (under 18 years of age) must have a legal guardian present to both fill out the “Medical History Update Form” and to sign the “Disclosure and Consent Form”.
4. It is important to avoid smoking for at least one week before the surgery and one week following the surgery.

**If you are having IV (intravenous) conscious sedation:**

1. Do not eat or drink anything (including water) for at least six hours prior to your appointment. Failure to do so may result in the canceling and future rescheduling of your appointment.
2. **A responsible adult, over 18 years of age, should accompany you to the office and should remain in the office during the entire procedure. Following the sedation, this responsible adult should be physically capable of assisting and accompanying you home and should remain with you for the next 24 hours.**
3. For the first 24 hours following sedation, you should refrain from the following: driving an automobile; operating heavy machinery; making legal decisions; drinking alcoholic beverages; or, engaging in any activity that requires alertness.
4. There are important differences between general anesthesia (being completely asleep) and IV conscious sedation. If you have any questions about the IV conscious sedation process, please feel free to contact Dr. Williams at 972.743.6561 prior to the procedure.

I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction.

\_\_\_\_\_  
Signature of Patient (or Patient’s Guardian)

\_\_\_\_\_  
Date

**NOTE: If you have any concerns or questions about the surgery, please contact Dr. Williams at 972.743.6561 or by email at scott@kswdds.com.**



**K. SCOTT WILLIAMS, D.D.S., P.A.**  
— General Dentist Providing Oral Surgery Services —

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**MEDICAL HISTORY UPDATE FORM**

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ DOS \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Address \_\_\_\_\_ City/ST \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_ Phone \_\_\_\_\_  
Escort/Driver \_\_\_\_\_ Phone \_\_\_\_\_  
Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_ Zip \_\_\_\_\_  
Ht \_\_\_\_\_ Wt \_\_\_\_\_ Gender at Birth \_\_\_\_\_ Dentist's Name \_\_\_\_\_

*Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire, and there may be additional questions concerning your health.*

- |                                                                                                        |                                                                 |
|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. Are you in good health?..... Yes No                                                                 | i. AIDS or HIV infection..... Yes No                            |
| 2. Has there been any change in your general health within the past year? ..... Yes No                 | j. Thyroid problems..... Yes No                                 |
| 3. My last physical examination was on _____                                                           | k. Respiratory problems, bronchitis, etc. Yes No                |
| 4. Are you now under the care of a physician?.... Yes No                                               | l. Sleep apnea or snoring during sleep..... Yes No              |
| Being treated for depression, anxiety, or other mental health concerns? ..... Yes No                   | m. Stomach ulcer or hyperacidity ..... Yes No                   |
| If so, for what condition(s)? _____                                                                    | n. Kidney trouble ..... Yes No                                  |
| 5. The name and address of your physician is: _____                                                    | o. High or low blood pressure..... Yes No                       |
| _____                                                                                                  | p. Sexually transmitted disease ..... Yes No                    |
| 6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No | q. Epilepsy/other neurological disease..... Yes No              |
| 7. Any recreational drug use, including marijuana? Yes No                                              | r. Problems with the spleen ..... Yes No                        |
| 8. Are you taking any medicine(s), including GLP-1 drugs or non-prescription medicine(s)?..... Yes No  | 11. Have you had abnormal bleeding? ..... Yes No                |
| If so, what medicine(s) are you taking? _____                                                          | Or required a blood transfusion? ..... Yes No                   |
| 9. Do you take medications for osteoporosis?.. Yes No                                                  | 12. Do you have any blood disorder such as anemia? ..... Yes No |
| 10. Do you have or have you had any of the following diseases or problems?                             | 13. Have you been treated for a tumor? ..... Yes No             |
| a. Damaged or artificial heart valves, heart murmur, or rheumatic heart disease ..... Yes No           | 14. Are you allergic or have you had a reaction to:             |
| b. Diagnosed cardiovascular issues ..... Yes No                                                        | a. Local anesthetics..... Yes No                                |
| c. Osteoporosis..... Yes No                                                                            | b. Penicillin or other antibiotics ..... Yes No                 |
| d. Cancer requiring IV chemotherapy ..... Yes No                                                       | c. Sulfa drugs ..... Yes No                                     |
| e. Asthma or hay fever ..... Yes No                                                                    | d. Barbiturates, sedatives, sleeping pills .... Yes No          |
| f. Fainting spells or seizures ..... Yes No                                                            | e. Aspirin ..... Yes No                                         |
| g. Diabetes..... Yes No                                                                                | f. Iodine ..... Yes No                                          |
| h. Hepatitis, jaundice, or liver disease..... Yes No                                                   | g. Codeine or other narcotics ..... Yes No                      |
|                                                                                                        | h. Other _____                                                  |
|                                                                                                        | 15. Have you had a joint replacement (hip/knee)? Yes No         |

**Women**

- |                                                      |
|------------------------------------------------------|
| 16. Are you pregnant? ..... Yes No                   |
| 17. Do you have any menstrual problems? ..... Yes No |
| 18. Are you nursing? ..... Yes No                    |
| 19. Are you taking birth control pills?..... Yes No  |

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. If your medical history is complex or if you feel you would like to provide us with additional information, it would be helpful for us if you would use the back of this form to write out a chronological narrative of your medical history.

\_\_\_\_\_  
Signature of Dr. Williams

\_\_\_\_\_  
Signature of Patient (or Patient's Guardian/Relationship)

**\*\* RETURN THIS COMPLETED FORM TO YOUR DENTIST PRIOR TO SURGERY \*\***



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**PATIENT TREATMENT RECORD—\*FOR DENTIST’S USE ONLY BELOW\***

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ DOS \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Acknowledgment: Receipt of Notice of Privacy Practices (Form 7 of 7) allows for contact by:  Phone  Email  Mail

Medical History Findings/ROS \_\_\_\_\_

Current Medications \_\_\_\_\_

Allergies \_\_\_\_\_

Pre-op Meds (last 24 hrs.) \_\_\_\_\_

Patient Surgical/Anesthesia History \_\_\_\_\_

Family Surgical/Anesthesia History \_\_\_\_\_

Smoker: Y / N Vape/Smokeless: Y / N EtOH/Rec. drug abuse: Y / N Sleep Apnea: Y / N Pregnancy: Y / N / NA

Procedure Planned \_\_\_\_\_

Diagnostic Criteria: Perio \_\_\_\_ Crowding/Ortho \_\_\_\_ Prev. Pain/Swelling \_\_\_\_ Non-Restorable \_\_\_\_ Cyst \_\_\_\_ Pt. Election \_\_\_\_

Pre-Operative Imaging:  CBCT  Pano  PA  Other \_\_\_\_\_ Imaging Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Dental Office \_\_\_\_\_ Total Fee \_\_\_\_\_

**Pre-Operative Sedation/Anesthesia Checklist**

- Medical history reviewed
- Known allergies reviewed
- Patient surgical/anesthesia history reviewed
- Family surgical/anesthesia history reviewed
- Patient medications reviewed/modified
- Pre-operative instructions given (*written & verbal*)
- Post-operative instructions given (*written & verbal*)
- Documentation of physical examination (*including ASA classification, NPO status, and pre-operative vitals—height, weight, BP, HR, RR*)
- Documentation of anesthesia-specific physical examination (*including Mallampati score and/or Brodsky score and auscultation*)
- Pre-procedure equipment readiness check completed (*monitors on/operating, sufficient O2 supply, AED/BVM/OPA/LMA present*)
- Pre-procedure emergency readiness check completed (*emergency protocols present and emergency roles reviewed*)
- Pre-procedure treatment review completed (*confirmation of correct patient & procedure*)
- Reversal/resuscitation agents are present, out, and unexpired
- Pediatric/high-risk pre-operative considerations addressed
- Medical consult (*as needed*)
- Consent(s) signed: \_\_\_\_ Dental/oral surgery \_\_\_\_ Supplemental  
\_\_\_\_ Implant \_\_\_\_ Notice of Privacy Practice Acknowledgment

Explanation of any omissions \_\_\_\_\_ Individuals present \_\_\_\_\_

Physical Exam: Ht \_\_\_\_\_ Wt \_\_\_\_\_ BMI \_\_\_\_\_ Auscultation Findings: WNL; Rales; Wheezes; Other \_\_\_\_\_

Mallampati/Brodsky Score \_\_\_\_\_ ASA Classification \_\_\_\_\_ Oral Cx Exam: E/O: - + \_\_\_\_\_ I/O: - + \_\_\_\_\_

Pre-operative Vitals: EKG \_\_\_\_\_ SpO2 \_\_\_\_\_ BP \_\_\_\_\_ HR \_\_\_\_\_ RR \_\_\_\_\_ N.P.O. > \_\_\_\_\_ hrs.

Treatment/Clinical Notes \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Continually evaluated color of mucosa, skin, or blood  Continually evaluated ventilation: *precordial steth.; end-tidal CO2; verbal comm. w/ pt.*

Ligated airway protection used  Sutures: *silk; gut; vicryl;* \_\_\_\_\_  Post-Operative/Anesth. Instructions O&W

D/C criteria met per Rule 110.5(6) C&D Doctor’s Signature \_\_\_\_\_ Date \_\_\_\_\_





**DISCLOSURE AND CONSENT – DENTAL AND ORAL SURGERY**

**TO THE PATIENT:** *You have the right, as a patient, to be informed about your condition and about the recommended surgical, medical, or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you can give or withhold your consent to the procedure.*

I voluntarily request K. Scott Williams, D.D.S., P.A. and such associates, technical assistants, and other healthcare providers as they may deem necessary, to treat my condition which has been explained to me as:

**Non-restorable, periodontally-involved, and/or impacted teeth (7220, 7230, 7240, 7250)** \_\_\_\_\_

I(we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me(us), and I(we) voluntarily consent and authorize these procedures under local anesthesia supplemental by: \_\_\_\_\_ IV Sedation

**Surgical Extraction of Teeth (7210)** \_\_\_\_\_

I(we) understand that my doctor may discover other or different conditions which require additional or different procedures than those planned. I(we) authorize my doctor and such associates, technical assistants, and other healthcare providers to perform such other procedures which are advisable in their professional judgment.

I(we) understand that no warranty or guarantee has been made to me as to result or cure. I(we) have been given both oral and written post-operative instructions, and I(we) agree to personally contact Dr. Williams in the event I(we) have a problem. I(we) will follow his instructions until that problem has been satisfactorily resolved. I(we) realize that in the event I(we) develop certain complications, I(we) may miss school or work schedules or I(we) may incur additional, unexpected expenses, including, but not limited to, expenses for other dentists, doctors, or medical facilities.

I(we) understand Dr. Williams is not employed by my dentist but is an independent contractor and will receive a portion of the fee paid to my dentist for these services. I(we) have chosen Dr. Williams from the alternatives I(we) have been offered to perform my dental surgery. I(we) understand that Dr. Williams is a general dentist, and I(we) give Dr. Williams and such associates permission to video or photograph procedure(s) for diagnostic and/or teaching purposes only.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I(we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, pain, swelling, bleeding, bruising, allergic reactions, cardiac arrest, brain injury, and even death. I(we) also realize that the following risks and hazards may occur in connection with this particular procedure:

- \_\_\_\_\_ 1. Temporary or permanent nerve injury resulting in altered sensations or numbness of the lips, chin, tongue, teeth, and/or gums
- \_\_\_\_\_ 2. Damage to adjacent teeth and/or dental restorations
- \_\_\_\_\_ 3. Soreness at injection sites and/or along veins, as well as discoloration of the injection sites, bleeding, bruising, or swelling of the face and/or jaw
- \_\_\_\_\_ 4. Opening of the sinus requiring additional treatment
- \_\_\_\_\_ 5. Jaw fracture, muscle spasms, and/or limited opening of jaws for several days or weeks
- \_\_\_\_\_ 6. Small root fragments remaining in the jaw due to an increased possibility of surgical complications
- \_\_\_\_\_ 7. Jaw joint (TMJ) tenderness, soreness, pain, or locking, which may be temporary or permanent
- \_\_\_\_\_ 8. Dry socket occurrence when a blood clot does not form properly, which can be extremely painful if not treated
- \_\_\_\_\_ 9. Infection requiring additional procedures
- \_\_\_\_\_ 10. Other \_\_\_\_\_

I(we) understand that IV conscious sedation (“twilight sleep”) and other forms of supplemental sedation involve additional risks and hazards, but I(we) request the use of IV conscious sedation and/or other forms of supplemental anesthesia to assist in the relief and protection from pain during the planned and additional procedures. I(we) realize the IV conscious sedation and/or other forms of supplemental anesthesia may have to be changed possibly without explanation to me(us). I(we) understand this is not general anesthesia (being completely asleep), and that it is unlikely, but I may have unpleasant memories of the procedure.

I(we) understand that certain complications may result from the use of any IV sedative or other form of anesthesia, including respiratory problems, drug reactions, paralysis, brain damage, or even death. Other risks and hazards which may result from the use of IV sedation or other sedatives or anesthetics range from minor discomfort to injury of the vocal cords, teeth, and/or eyes.

I(we) have been given an opportunity to ask questions about my(our) condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I(we) believe that I(we) have sufficient information to give this consent.

I(we) certify this form has been fully explained to me(us), that I(we) have read it or have had it read to me(us), that the blank spaces have been filled in, and that I(we) understand its contents.

DATE \_\_\_\_\_ TIME \_\_\_\_\_

Signature of Patient or Other Legally-responsible Person	/ Patient's Name (Please Print)

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_



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**SUPPLEMENTAL DISCLOSURE & CONSENT**

**INFORMATION FOR PATIENTS REGARDING POSSIBLE CHANGES IN SENSATIONS OF THE LIP, CHIN, OR TONGUE FOLLOWING DENTAL SURGERY**

Dental surgery, like any other surgery, has certain inherent risks and limitations that may occur despite the experience and skill of the doctor. Following your surgery, it is possible that you may experience either temporary or permanent changes in the sensation or feelings of your lip, chin, or tongue. Permanent changes in sensation of the affected areas are extremely rare.

***WHAT CAN CAUSE IT?***

Because the nerves that supply these regions are close to the area where the surgery is performed, the nerves may not function normally for a while afterwards. These nerves affect sensation only and not movement.

The most common cause of this type of injury is from the pressure that can occur during either the removal of a tooth root or by the placement of an implant in the lower jaw. Occasionally, hooks or curves on the root may tear some of the nerve fibers. Another possible cause of injury is during the administration of the local anesthesia (numbing medicine). X-rays are helpful but cannot tell us the exact location of the important structures. When the nerve is especially close to the site of the surgery, it could be nicked or cut. Additionally, the incidence and severity of nerve injuries increases with age. This is particularly true for lower wisdom teeth. Further, sometimes sensation is affected without knowing exactly what caused it.

***HOW LONG WILL IT LAST?***

The likelihood that a change in sensation will occur and how long it will last can depend on many factors, including position of the tooth, the nerve, or the difficulty of the procedure. The duration of the condition is unpredictable and different in each case. It may last a few days, weeks, or months, and in very rare instances, may be permanent. In the majority of cases, the sensory loss gradually returns to normal although you may not be aware of any immediate improvement. Nerve tissue is the slowest tissue in the body to heal, and it can be weeks or months before you notice significant improvements. Nonetheless, it is important for you to stay in touch with us, so we may advise you of your specific circumstances.

***HOW CAN I TELL IF I AM GETTING BETTER?***

During nerve recovery, you may notice changes such as tingling, as if a local anesthetic is wearing off. Other sensations may also be present. Do not be alarmed; this is often a positive sign. It is important for you to help us in recording any changes in your symptoms so that we may better answer your questions and advise you as to your prognosis.

***WHAT IF IT DOESN'T GET BETTER? CAN ANYTHING BE DONE?***

If there has been absolutely no improvement in six weeks, then depending on your case, microsurgical repair could be considered. We can further counsel you on this possibility, and you will be referred to a specialist who is experienced and knowledgeable in this area.

***IN SUMMARY***

Remember, in the overwhelming number of instances of altered sensation, all or most of the normal sensation will return. If residual symptoms do remain, the risks involved with surgical repair may not be warranted, in that spontaneous, post-operative recovery may take up to two years to occur. By keeping in close contact with us, we are better able to advise you throughout your recovery process to insure optimum results.

\_\_\_\_\_  
Patient's Name (printed)

\_\_\_\_\_  
Signature of Patient (or Patient's Guardian)

\_\_\_\_\_  
Signature of Dr. Williams

\_\_\_\_\_  
Date Signed



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**POST-OPERATIVE INSTRUCTIONS**

- In your post-op bag that we are sending home with you, you have written instructions, extra gauze (which I will show you how to change in a moment), and your prescriptions form. On the outside of the bag there is a sticker with pertinent information, along with Dr. Williams's contact number and his website that has helpful videos, how to's, and post-op instructions as well.
- Your prescriptions are for an **ANTIBIOTIC** (Penicillin or Azithromycin/Z-Pak, typically), which you will want to start at the time indicated on the outside of your post-op bag. Make sure you take **ALL of this prescription** (there is one refill on the antibiotic, if needed). You have been given two medicines already, either through the IV or by injection. One is a steroid to reduce inflammation, and one is an NSAID, which is an anti-inflammatory—both of which will reduce the potential of swelling. Because you have been given these medications already, you will not need to take any medicines for pain for six hours (the time will be written on the sticker on the outside of your post-op bag). At the time indicated, you will begin taking your **prescription IBUPROFEN 600mg AND TYLENOL EXTRA STRENGTH 500mg TOGETHER**. Do not alternate these medications. Tylenol Extra Strength is an over-the-counter medication, and it comes in 500mg tablets, so you will need to take one. You will repeat this dosage combo **every eight hours for four days**. After three days, take as needed/if needed. This dosage regimen is typically all you will need to take care of your discomfort. You have also been given a prescription for **ZOFRAN in the event of nausea**. There is also a prescription for a medicated mouth rinse (**PERIDEX**) which you will not start using until tomorrow, 24 hours after surgery. Use this rinse **AFTER** you have eaten and brushed your teeth in the morning and the last thing before bed every night **for at least one week**. In addition to PERIDEX, rinse with warm salt water beginning the day after surgery every time you have a meal or snack. It is also a good idea to rinse after you drink anything other than water. **On the two days after your surgery day, you will just gently rinse** (no vigorous rinsing/swishing/spitting) by rocking your head back and forth and letting it fall out of your mouth while leaning over the sink. Beginning on the third day after your surgery day, rinse vigorously every time you eat or drink. Continue vigorous rinsing until sockets heal.
- Discomfort is directly related to swelling. If we can keep you from swelling, or limit the amount of swelling that you have, we can keep you comfortable. Once you get home, you will want to **use ice packs** by placing on the outside of both cheeks **20 minutes on/off** throughout the day as much as possible. (Ice in Ziplock baggies, with a thin cloth wrapped around it, works great if you do not have ice packs.) If you do not ice today, you have the increased potential for swelling. Ice is not indicated after 24 hours.
- **Change out your gauze in one hour, and then repeat the process once every hour until you remove the gauze and it is just pink**. At that point, you have pretty much stopped bleeding and can leave the gauze out. You want to keep **direct pressure** on the gauze **by firmly biting down**; the harder you bite, the faster you will stop bleeding. If you continuously change the gauze and it is red and saturated, this is an indication that you are not biting hard enough on the gauze and/or the gauze is not properly placed over the sockets. **When it is time to change the gauze, that is the ideal time to eat/drink**, then replace the gauze, if necessary. **DO NOT SLEEP WITH GAUZE IN YOUR MOUTH** as doing so would present a choking hazard.
- **For the next three days, you will want to avoid any carbonated beverages** (soda, beer, champagne). You will also want to **avoid anything that creates a suction in the mouth** (no drinking through a straw, sucking on water/sports bottles or juice boxes, no chewing gum/mints/suckers, and no smoking or vaping).
- **NO rinsing your mouth or brushing your teeth for the first 24 hours. After that, you should resume brushing your teeth**. Brush your teeth as you normally would, including your back teeth. Tenderness and slight bleeding are to be expected. The cleaner you keep your mouth, the faster you will heal. Any food debris, plaque, or bacteria in the mouth delays healing and increases the potential for swelling, infection, or dry socket. After you brush your teeth, you can put water in your mouth, rinse by shaking your head from side-to-side, and lean head over the sink, letting water fall out into the sink. **No vigorous rinsing/swishing/spitting for the first two days after your surgery day. Beginning on the third day after your surgery day, you can start a vigorous rinse** with regular water, warm salt water, or medicated mouth rinse **after every meal or snack** to make sure that sockets stay clean.



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**Post-Operative Instructions (continued)**

- Depending on your metabolism, you could be numb anywhere from 8-24 hours.
- As far as your diet, stay with just **liquids the remainder of today** (broth, yogurt, pudding, milkshakes thick enough to eat with a spoon, protein drinks, and ice cream). It is important to keep up your calorie intake, as your body needs the calories to heal. Also, it is important to stay hydrated. **Starting tomorrow, eat a soft diet**, such as yogurt, pasta, baked/mashed potatoes, scrambled eggs, oatmeal, and flaky fish. Do not eat anything hard, crunchy, or chewy. Gradually start adding more solid foods into your diet after a week or so.
- As far as returning to school, you will miss the remainder of today and probably tomorrow (play it by ear). You will want to refrain from sports activities or marching band for 3 days. If you play a wind instrument, please refrain from doing so for 1-2 weeks.
- Regarding **physical activity**, you should rest for the first 24-48 hours. Patients who have had sedation should refrain from driving an automobile or from engaging in any task that requires alertness for the next 24 hours.

**\*\*If you have any questions or concerns,\*\*  
please call or text Dr. Williams at 972.743.6561.**



**ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received a copy of K. Scott Williams, D.D.S., P.A.’s Notice of Privacy Practices effective 1/1/26.

Patient’s Name (please print) \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date Signed

\*\*\*\*\*

I am a parent or legal guardian of \_\_\_\_\_ (patient’s name). I have received a copy of K. Scott Williams, D.D.S., P.A.’s Notice of Privacy Practices effective 1/1/26.

Parent or Legal Guardian’s Name (please print) \_\_\_\_\_

Relationship to Patient:       Parent       Legal Guardian

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date Signed

I authorize the doctor and his staff to contact me by \_\_\_ phone \_\_\_ email \_\_\_ mail (check all that apply)

\*\*\*\*\*

If the patient or the patient’s parent/legal guardian did not sign above, staff member must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and what efforts were used to obtain the signature.

Notice of Privacy Practices effective 1/1/26 given to individual on \_\_\_\_\_ (date)

In Person    Email    Mail    Other \_\_\_\_\_

Reason patient or patient’s parent/legal guardian did not sign this form:

- Did not want to sign
- Did not respond after more than one attempt
- Other \_\_\_\_\_

\_\_\_\_\_  
Staff Member’s Name (please print)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature of Staff Member

\_\_\_\_\_  
Date Signed