EXCLUSIVE ORAL SURGERY, LLC

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AGREEMENT FOR SHARED RESPONSIBILITY FOR CONTINUING CARE AND FOLLOW-UP

Patient's Name:_____

Address:_____

_____

Telephone:_____

Name and telephone of alternate person to contact if I am not at the above number:

_____

I have been told that my condition will require continuing follow-up, sometimes for years, in order to assure that there is proper healing and/or no recurrence of the disorder.

I acknowledge that my doctor has advised me of the importance of returning for long-term follow-up, which, if not done, may cause infection or other complications to go undetected, and which could lead to a recurrence, relapse or serious complication in treatment of my disorder. I understand that if I do not return for proper continuing care, my condition may progress to require more advanced treatment or further surgery, or in rare cases may be life threatening.

I agree to comply with regularly scheduled exams when notified by this office, understanding that I may choose a convenient appointment, but not postpone care beyond a reasonable time. When notified of my appointment, I will call to confirm as soon as possible.

I also understand that if I feel there are adverse changes in my symptoms or condition between scheduled visits, I should notify this office immediately.

_____

Patient's (or Legal Guardian's) Signature Date

_____

Doctor's Signature Date