The Dental Place of Tamarac

Patient Information

Today's Date: _____ Phone Number: _____

First Name: _____ Last Name: _____

Sex: [ ]Female [ ]Male Marital Status: [ ]Married [ ]Single [ ]Child

Social Security: _____ Date of Birth: _____

Address: _____

_____

Email: _____

Responsible Party Information

First Name: _____ Last Name: _____

Sex: [ ]Female [ ]Male Social Security:_____

Date of Birth: _____ Phone Number: _____

Best Time to Call: _____

Address: _____

Email: _____

Employment Information

Employer Name:_____ Occupation:_____

Address:_____

Who may we thank for your referral?

_____

Consent for Dental Treatment

I request and authorize the doctors and staff at The Dental Place of Tamarac to examine, clean and provide myself/child with comprehensive oral evaluation and dental treatment including, but not limited to fluoride, fillings, crowns, and extractions if required. I further request and authorize dental radiographs to be taken, as they may be necessary for the Doctors of The Dental Place of Tamarac to diagnose/treat myself/child dental condition. I will allow photographs to be taken for diagnostics or educational purposes. I understand that I will be responsible for any charges incurred on this account for dental treatment.

I have given an accurate report of my physical, mental, dental health history. I have also reported any prior allergic or unusual reactions to medications, latex, foods or metal and any other disease or condition, including pregnancy.

I agree to inform the Doctors and Staff of The Dental Place Of Tamarac of any changes in medical history. This authorization is valid until revoked by me in writing.

Prothesis and Invisalign: The entire cost or your portion must be paid on the day impressions are taken for prothesis and before approving clincheck for Invisalign. This is necessary because our office must pay laboratory costs when treatment is ordered not on completion.

_____ _____

Patient Name Date

_____ _____

Patient Signature Relationship to Patient

Consent & Acknowledgement of Receipt of Privacy Notice (HIPAA)

I have been given a copy of Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices, and prior to implementation will mail a copy of the revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment or healthcare operations and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent. This consent is given with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as this original.

3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information, and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____ _____

Patient Signature Date

Broken Appointment Protocol

I, _____understand that there will be a charge of $ 40.00 if I do not provide a 48 hour notice before canceling an appointment. Our office prides itself on always spending quality time with our patients. Unfortunately, this policy must be implemented to ensure that the doctor can offer care to patients who have been waiting for days or weeks for their appointments. Thank you for your understanding in this matter.

Insurance Coverage and Billing

We strive to help our patients understand the coverage of their insurance and we will bill the claims to their insurance company, however, your insurance policy is between you and your insurance company, not between the doctor and the insurance. Insurance estimates are not a guarantee of payment, and the patient is responsible for all fees not paid by the insurance company.

Financial Agreement

Our goal is for patients to clearly understand their treatment needs, as well as their financial responsibility at the time of service. We want dental treatment to be affordable for all of our patients. Therefore, we offer the following payment options:

Social Media Photo Release

I hereby grant The Dental Place of Tamarac permission to upload photos of myself or my child to their website and Social Media Sites. In addition I waive my rights to any compensation arising out of the use of the photo or videos. I release and discharge The Dental Place of Tamarac from any and all claims arising out of use of the photos or videos for any lawful purpose such as for publicity, illustration, advertising, and or Web Content.

_____ _____

Patient Signature (or Guardian) Date