Point Dental Arts

Michael Karwacki, DMD, MS

Date:

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:	
Street Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Date of Birth:	Gender:	Social Security Number:	
Email Address:			
Occupation:	Employer:		
Emergency Contact Name:	Relationship:	Phone Number:	

DENTAL INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:	
Policy Number:	Secondary Policy Number:	
Group Number:	Secondary Group Number:	
Policy Holder Name:	Date of Birth:	SSN:
Relationship to Patient:		

DENTAL HISTORY

Reason for today's visit?

Are you currently experiencing any dental pain or discomfort? ☐ Y ☐ N If yes, where?

Date of last dental visit? What was done at this visit?

Date of last dental x-rays?

Former Dentist: City, State:

Who may we thank for referring you?

Please check yes or no if you have had problems with any of the following:

Bad breath	☐ Y ☐ N	Pain to chew, bite, or swallow	☐ Y ☐ N	Have you ever had a serious injury to your head or mouth? ☐ Y ☐ N
Bleeding gums	☐ Y ☐ N	Sensitivity hot/cold	☐ Y ☐ N	If yes, please explain:
Blisters/canker sores	☐ Y ☐ N	Sensitivity to chewing/biting	☐ Y ☐ N	
Growths in the mouth	☐ Y ☐ N	Sensitivity to sweets	☐ Y ☐ N	
Smoking/tobacco use	☐ Y ☐ N	Does dental treatment make you nervous?	☐ Y ☐ N	
Clicking/popping Jaw	☐ Y ☐ N			Have you ever had problems with dental treatment in the past? ☐ Y ☐ N
Jaw pain on open/close	☐ Y ☐ N	How often do you brush?		If yes, please explain:
Pain around ear	☐ Y ☐ N	How often do you floss?		
Grinding/clenching teeth	☐ Y ☐ N	Are you happy with your smile?	☐ Y ☐ N	
Dry mouth	☐ Y ☐ N	If not, please list your concerns:		
Mouth breathing	☐ Y ☐ N			Have you ever had a reaction to dental anesthesia? ☐ Y ☐ N
Snoring	☐ Y ☐ N			If yes, please explain:
Trouble breathing during sleep	☐ Y ☐ N			
Loose/broken filings	☐ Y ☐ N			

MEDICAL HISTORY

Primary Physician: Phone number:

Date of last physical:

Please list any prescription medications, over the counter medicines, vitamins, herbs/supplements you are taking:

Are you allergic to or have you had a reaction to:

Aspirin	☐ Y ☐ N	Latex	☐ Y ☐ N	If yes, please provide information about your experience:
Barbiturates, sedatives, sleeping pills	☐ Y ☐ N	Local Anesthetics	☐ Y ☐ N	
Codeine or other narcotics	☐ Y ☐ N	Metals	☐ Y ☐ N	
Penicillin or other antibiotics	☐ Y ☐ N	Hay fever/seasonal allergies	☐ Y ☐ N	
Iodine	☐ Y ☐ N	Other	☐ Y ☐ N	
Sulfa Drugs	☐ Y ☐ N			

Have you ever taken a bisphosphonate medication (such as Fosamax, Actonel, Atelvia, Didronel, Bonvia)? ☐ Y ☐ N

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen"? ☐ Y ☐ N

Are you taking any blood thinners (such as Coumadin, Warfarin, Plavix, Xarelto, Aspirin)? ☐ Y ☐ N

Do you have a history of substance abuse? ☐ Y ☐ N

Are you taking hormonal replacements? ☐ Y ☐ N

Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control? ☐ Y ☐ N

Have you had a serious illness, operation or been hospitalized in past 5 years? ☐ Y ☐ N
If yes, please explain:

Do you have or been diagnosed with any of the following conditions?

Heart Health

☐ Y ☐ N Pacemaker/implanted defibrillator
☐ Y ☐ N Artificial (prosthetic) heart valve
☐ Y ☐ N Previous infective endocarditis
☐ Y ☐ N Congenital heart disease (CHD)
☐ Y ☐ N Arteriosclerosis
☐ Y ☐ N Coronary artery disease
☐ Y ☐ N Damaged heart valves
☐ Y ☐ N Heart attack
☐ Y ☐ N Heart murmur
☐ Y ☐ N History of atrial fibrillation
☐ Y ☐ N Rhematic heart disease
☐ Y ☐ N Stroke

Respiratory Health

☐ Y ☐ N Asthma
☐ Y ☐ N Bronchitis
☐ Y ☐ N Emphysema
☐ Y ☐ N Sinus trouble
☐ Y ☐ N Tuberculosis

Skeletal Health

☐ Y ☐ N Arthritis
☐ Y ☐ N Osteoporosis
☐ Y ☐ N Paget's disease
☐ Y ☐ N Joint replacement

Cancer

☐ Y ☐ N Chemotherapy
☐ Y ☐ N Radiation
☐ Y ☐ N Organ or bone marrow/stem cell transplant
☐ Y ☐ N Multiple myeloma

Circulatory Health

☐ Y ☐ N Anemia
☐ Y ☐ N Blood transfusion
☐ Y ☐ N Hemophilia
☐ Y ☐ N High or low blood pressure

Brain/Mental Health

☐ Y ☐ N Anxiety
☐ Y ☐ N Depression
☐ Y ☐ N Post traumatic stress disorder
☐ Y ☐ N Eating disorder
☐ Y ☐ N Other mental health disorder
☐ Y ☐ N Epilepsy
☐ Y ☐ N Neurological disorder
☐ Y ☐ N Headaches
☐ Y ☐ N Traumatic brain injury or concussion

Digestive Health

☐ Y ☐ N GI disease
☐ Y ☐ N Acid reflex/heartburn (GERD)
☐ Y ☐ N Stomach ulcers

Immune Health

☐ Y ☐ N AIDS or HIV infection
☐ Y ☐ N Lupus
☐ Y ☐ N Rheumatoid Arthritis
☐ Y ☐ N Immune deficiency
☐ Y ☐ N Frequent infections

Other

☐ Y ☐ N Chronic pain
☐ Y ☐ N Glaucoma
☐ Y ☐ N Diabetes (type 1 or 2)
☐ Y ☐ N Hepatitis, jaundice or liver disease
☐ Y ☐ N Kidney problems
☐ Y ☐ N Sexually transmitted infection
☐ Y ☐ N Thyroid problems

Please list any other conditions:

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature: _____ Date: _____

Point Dental Arts

Michael Karwacki, DMD, MS

Authorization to Release Information

I hereby authorize the above named dentist(s) to provide any insurance company(s), claim administrator(s), and consulting health care professionals, information concerning health care advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluation and administering claims for benefits.

_____ _____

Patient or Authorized Guardian Signature Date

Point Dental Arts

Michael Karwacki, DMD, MS

Financial Agreement

Thank you for choosing Point Dental Arts as your dental health care provider. We are committed to providing you with the highest quality dental care. Please take the time to familiarize yourself with our financial policies.

As a condition of your treatment by this office, financial arrangements must be made in advance. If you have dental insurance that we accept, we will gladly submit all paperwork needed to collect payment from that insurance. Please keep in mind that most insurance plans do not pay for the entire cost of your dental care. It is the patient's responsibility to know the details of their individual insurance policy. **Co-payments & deductibles are due at the time of service. The total balance, whether your insurance company pays or not, is <u>your</u> responsibility.**

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time of service.

CANCELLATION POLICY: If you need to cancel or change your appointment, we require a 24 hour notice. If this is not met:

- There will be a $100 charge for late cancellations under 24 hours
- There will be a $100 charge for a no show appointment

By signing below, you have been informed and understand these policies.

Signature: _____

Print Name: _____

Date: _____

Point Dental Arts

Michael Karwacki, DMD, MS

Authorization and Consent To Send Unencrypted Patient Information by Email and Other Electronic Means

I authorize Point Dental Arts to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Point Dental Arts health care operations. The patient information that may be emailed may include my xrays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Point Dental Arts may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Point Dental Arts does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Point Dental Arts already sent before receiving my written instructions to stop.

Signature: _____

Print Name: _____

Date: _____

Point Dental Arts

Michael Karwacki, DMD, MS

Informed Consent- General Dentistry

Choosing among dentally reasonable treatment alternatives is a shared responsibility of dentists and patients. In the usual care, a dentist will recommend a course of treatment. While a patient often decides to adopt the recommendation, the ultimate decision is for the patient provided the choice is dentally reasonable. Under the law in New Jersey, a dentist is obligated to inform a patient of dentally acceptable treatment alternatives and their attendant probable risks and outcomes, and the costs relative to the treatment that is recommended and/or rendered, so a patient can make a decision that is informed. This form, together with our conversation about treatment alternatives, risks and outcomes, is intended to fulfill Dentist's legal obligation to obtain informed consent.

1. Treatment Plan. The Dental Services to be provided include one or more of the following: exam, cleaning, radiographs, fluoride, sealants, whitening, fillings, veneers, crowns, bridges, root canals, simple extractions, surgical extractions, bone grafting, implant placement, implant restoration, dentures, periodontal procedures, and/or orthodontics.

2. Changes in Treatment Plan. During the course of treatment, procedures may need to be added, expanded or changed because conditions are found that were not identified during examination and first were observed during the course of treatment. The most common include the need for root canal therapy and more extensive restorative procedures, like crowns, bridges, or implants. Permission is herby given to perform any additional or expanded dental services that the Dentist determines are necessary. Further, in the Dentist's discretion, I may be referred to a specialist for further treatment, the cost of which is my responsibility.

3. Drugs, Medication, and Sedation. Drugs, medications or anesthesia/sedation can cause allergic and other reactions. Examples include, but are not limited to, swelling, redness, itching, vomiting, diarrhea, numbness or tingling of the lip, gum or tongue (which in rare cases may be permanent) and also in rare cases, anaphylactic shock. Since they also may cause drowsiness and impair coordination or awareness, a motor vehicle or hazardous device should not be operated before full recovery is achieved. I have informed the dentist of all drugs and medications I am taking or have taken within the last 30 days, as well as those that have been prescribed within the last 6 months but not taken, and all allergies and sensitivities of which I am aware. I have been informed and understand that failure to take drugs or medications as prescribed by Dentist may result in continued or aggravated infection and pain and potential resistance to effective treatment. In addition, antibiotics can reduce the effectiveness of birth control pills.

4. Fillings. The most common conditions encountered with filings are pain, sensitivity to temperature or pressure, fractures of teeth or roots, nerve damage, damage to other teeth, occlusal (bite) discrepancies, temporomandibular joint problems and occasional allergic reactions to filling materials.

5. Endodontic Treatment (Root Canal). Although root canal treatment to retain a tooth or teeth that otherwise might need to be extracted is very common dental procedure with a reported success rate over 90%, there are some risks and complications. The most common include swelling, soreness, infection, bleeding, trismus (restricted jaw opening), numbness or tingling of the lips, gum or tongue

(which in rare cases may be permanent), discoloration of adjacent teeth or soft tissue, perforation of the root, and fractures (splits) of the crown or root of the tooth or restoration. Occasionally, one of the delicate instruments used to perform a root canal may separate in the tooth. A failed root canal may require re-treatment, surgery, or extraction. Once a tooth has received root canal treatment, it tends to be more brittle and weak. To minimize the likelihood of a fracture, restoration with a crown is recommended. There is no guarantee that root canal treatment will save a tooth.

6. Crowns, Onlays/Inlays, Bridges, Veneers, Bonding. Sometimes, it is difficult or impossible to exactly match the color of artificial teeth or restorative materials with natural teeth. Although assistance will be provided by the dentist, it is my responsibility to make changes, if any, (including, for example, shape, size, fit, and color) before permanent cementation. After a temporary crown has been placed, it is essential to have the new crown cemented as soon as it is ready because the temporary crown is not intended to function as a permanent restoration. Failing to replace the temporary crown could lead to decay, gum disease, infections, problems with the bite and even loss of tooth. Further, if there if prolonged delay in placing thee permanent crown, it may no longer properly fit.

7. Periodontal (Gum) Health. Periodontal disease is a serious condition that causes gum inflammation and bone loss that can lead to tooth loss. Keeping this in mind, alternative treatment plans have been explained, including a consult with a periodontist, gum surgery, extractions, implants, and/or other removable or fixed prosthesis. Undertaking any dental procedures may have a future adverse effect on overall periodontal health, and also periodontal disease can reoccur after treatment. It is imperative to maintain proper homecare and regular check-up/maintenance visits at all times.

8. Extractions. Alternatives to extractions (tooth removal) have been explained, including root canal therapy, crowns, periodontal surgery, etc. Removing teeth does not always remove all of the infection if present, and it may be necessary to have further treatment. The risks involved include pain, swelling, spread of infection, dry socket, loss of feeling in other teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time, or fractured jaw. If complications arise during or following treatment, further treatment by a specialist may be required, the cost of which is my responsibility.

9. Dentures. Sore spots, altered speech, and difficulty eating are common problems when adjusting to wearing dentures. Immediate dentures may be uncomfortable and may require considerable adjustments and several relines. A permanent reline will be needed at a later date, which is not included in the denture fee. It is my responsibility to return for delivery of dentures. The failure to keep delivery appointment may result in poorly fitted dentures. If a remake is required due to these delays of over 30 days, additional fees may apply.

I have discussed treatment alternatives, risks, outcomes, and costs with the Dentist and have had all of my questions answered before making a decision. I understand that dentistry is not an exact science and that there are no guaranteed results. Unless otherwise provided by law, I understand that I am responsible for payment of all dental feeds not paid in full by any insurance or other applicable coverage. Having had adequate time to reflect upon the alternatives, I consent to the treatment, subject to changes in treatment plan, as detailed above.

Signature: _____

Print Name: _____

Date: _____

Point Dental Arts

Michael Karwacki, DMD, MS

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 03/01/2022, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY SEND HEALTH INFORMATION ABOUT YOU

Your protected health information ("PHI") includes information relating to your mental or physical health and to the health care provided to you, including materials like your dental records, dental x-rays, and payment records. Some documents containing PHI may include such sensitive personal information as a Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse records, positive HIV status, and other kinds of sensitive information.

Sometimes our dental practice needs to send PHI to the patient or to someone else, such as a specialist. There are various ways to send PHI, including email and other electronic means. Our dental practice does not encrypt email or other electronic forms of communication.

There is a risk that unencrypted information may be acquired by hackers or received by unintended recipients. If you are concerned about the security of PHI that may be sent unencrypted, please let us know and we will send it a different way, which may include providing the information to you to deliver.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations.

Treatment. We may disclose your health information to a specialist providing treatment to you.

Payment. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. Healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability
- Report child abuse or neglect
- Report reactions to medications or problems with products or devices
- Notify a person of a recall, repair, or replacement of products or devices
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. Our Privacy Official:

Michael Karwacki, DMD, MS
Telephone: 732- 899-4420
Address: 838 Beaver Dam Road, Point Pleasant, NJ 08742
E-mail: pointdentalarts@gmail.com

Point Dental Arts

Michael Karwacki, DMD, MS

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Private Practice provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of information but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosure will then cease
- The practice may condition receipt of treatment upon execution of this consent

May we call, email, or send a text to you to confirm appointments? ☐ Y ☐ N
May we leave a message on your answering machine at your home or cell phone? ☐ Y ☐ N
May we discuss your oral health with any member of your family? ☐ Y ☐ N
If yes, please name the members allowed:

Signature: _____

Print Name: _____

Date: _____