White River Dentist
Richard Schramm, D.M.D.
Tara Symancyk, D.D.S.
Mark Klampert, D.D.S.

1049 N. Hartland Road, PO Box 948
White River Jct, VT 05001-0948
802-295-2458
info@whiteriverdentist.com

Date:_____

PATIENT INFORMATION (Confidential)

Birthday:_____
SSN:_____

Name:_____ ☐Minor ☐Single ☐ Married

Address:_____ ☐ Separated ☐Divorced ☐Widowed

Telephone:_____ _____ _____
Home Cell Work

Patient employer:_____

Your E-Mail:_____

Married? Spouse's Name and Employer:_____

Minor? Parent or Guardian's Name, Address, and Phone:_____

College? _____Full time _____Part time Name of School:_____

School's Address:_____

Whom may we thank for referring you to us?_____

Person to contact IN CASE OF EMERGENCY:_____ Phone:_____

RESPONSIBLE PARTY INFORMATION

☐ Same as above

Name of person responsible for this account:_____ Relationship to Patient: _____

Address: _____ Birth date: _____

_____ Social Security #: _____

Telephone:_____ _____ _____
Home Cell Work

Drivers License#:_____State:_____

Is the responsible party a current patient in this office? _____YES _____NO

DENTAL INSURANCE INFORMATION

Name of Policy Holder:_____ Relationship to Patient:_____
Birth date of Policy Holder:_____ Social Security # of Policy Holder:_____
ID# of Policy Holder:_____
Policy Holder Employer:_____ Employer Phone #:_____
Name of Insurance Company:_____ Group #:_____

Do you have additional Dental Insurance? ☐ YES ☐ NO If yes complete the following:

Name of Policy Holder:_____ Relationship to patient:_____
Birth date of Policy Holder:_____ Social Security # of Policy Holder:_____
ID#: _____
Policy Holder Employer:_____ Employer Phone #:_____
Name of Insurance Company:_____ Group #: _____

White River Dentist

Richard Schramm, D.M.D.
Tara Symancyk, D.D.S.
Mark Klampert, D.D.S.

1049 N. Hartland Road, PO Box 948
White River Jct, VT 05001-0948
802-295-2458
info@whiteriverdentist.com
www.WhiteRiverDentist.com

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of White River Dentist ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means the patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact White River Dentist's Privacy Official at:

Lori Fernandes

P.O. Box 948 1049 North Hartland Road

White River Junction, Vermont 05001

802-295-2458

802-295-3985

info@whiteriverdentist.com

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised in June 2013

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made

only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and

genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is June 2013

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

White River Dentist
Richard Schramm, D.M.D.
Tara Symancyk, D.D.S.
Mark Klampert, D.D.S.

1049 N. Hartland Road, PO Box 948
White River Jct, VT 05001-0948
802-295-2458
info@whiteriverdentist.com
www.WhiteRiverDentist.com

Acknowledgement of Receipt of Notice of Privacy Policies

Your Privacy Is Important to Us

I have received a copy of the Notice of Privacy Practices of Drs. Schramm, Symancyk, and Klampert. I hereby authorize, as indicated by my signature below, Drs. Klampert, Schramm, and Symancyk to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____
Print Name

_____
Address

_____ _____
Signature of patient, parent, or guardian Date

Means of communication:

My home phone number is _____

My cell phone number is _____

My work phone number is _____

My email is _____

Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed:_____

2. _____ Date Added / Removed: _____

3. _____ Date Added / Removed: _____

***

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (please Specify) _____

Staff Person Initials _____

White River Dentist

Richard Schramm, D.M.D.
Tara Symancyk, D.D.S.
Mark Klampert, D.D.S.

1049 N. Hartland Road, PO Box 948
White River Jct, VT 05001-0948
802-295-2458
info@whiteriverdentist.com
www.WhiteRiverDentist.com

OFFICE POLICY REGARDING APPOINTMENTS FOR VERMONT MEDICAID RECIPIENTS

Thank you for choosing our office to help serve your dental needs. We look forward to working with you to better your dental health and to help you maintain a healthy smile. We accept appointments by reservation only. Our office hours are Monday through Thursday from 8am to 5pm and Friday from 8am to 12pm.

Every effort is made to keep on schedule, and we respectfully ask you to arrive on time for your appointment. We try to remind you of your appointment by your preferred means of communication. However, this is a courtesy only. If we are unable to contact you, your appointment card will serve as confirmation, and implies your obligation to be present. Vermont Medicaid recipients who miss an appointment, or break an appointment without a 1 business day notice will not be allowed to reschedule using your Vermont Medicaid plan.

Please be sure to check in with the front office coordinators upon your arrival. They will verify your information on file. We ask that you provide us with up to date address and contact information. Please be sure to bring your Vermont Medicaid card if you would like us to assist in filing your dental insurance claims. Please advise us immediately of any insurance coverage changes, exclusions or waiting periods.

If you have been waiting more than 20 minutes past your scheduled appointment time, please notify one of the scheduling coordinators. On the rare occasion that we do run late, we ask your patience and understanding. We will do our best to complete your scheduled treatment on time. Above all, your dental health and comfort is our main concern, and we will give you the individual attention necessary to complete your treatment.

I understand that once my annual benefits have been completed and used (maxed out) for the year, I accept full financial responsibility for all fees for further treatment and agree to pay White River Dentist any balance not covered by Vermont Medicaid for services rendered on the day of treatment.

Please advise us immediately of any circumstances that will interfere with your appointments. We look forward to working with you to better your dental health and to help you maintain a healthy smile.

I have read and understand the office policy above. I authorize Dr. Schramm, Dr. Symancyk, Dr. Klampert and their staff to proceed with my/my child's dental treatment.

Print name _____

Signature of patient or parent of minor _____

Date _____

White River Dentist

Richard Schramm, D.M.D.
Tara Symancyk, D.D.S.
Mark Klampert, D.D.S.

1049 N. Hartland Road, PO Box 948
White River Jct, VT 05001-0948
802-295-2458
info@whiteriverdentist.com
www.WhiteRiverDentist.com

PATIENT CONSENT

Clinical

1. I authorize Drs. Schramm, Symancyk, and Klampert to perform all recommended treatment with my permission.

2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

1. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18%APR may be automatically tabulated into my account if my balance is 30 days old or older. A $10.00 billing fee will also be added to your account if a balance is 30 days or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees. Please be aware that if there is a balance due on your account, we will not be able to schedule any further appointments until your balance is paid in full.

2. A $50.00 missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. I am aware that to hold down operating costs, a 24 hours notice of cancellation is required.

Insurance

1. I authorize the Practice to release to staff, hospitals, healthcare service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

2. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____

Signature of patient, parent, or guardian:_____ Date:_____

White River Dentist

Richard Schramm, D.M.D.
Tara Symancyk, D.D.S.
Mark Klampert, D.D.S.

1049 N. Hartland Road, PO Box 948
White River Jct, VT 05001-0948
802-295-2458
info@whiteriverdentist.com
www.WhiteRiverDentist.com

MEDICAL HISTORY

Patient Name _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	YES	NO	
Are you under a physician's care now?			If yes, please explain:
Have you ever been hospitalized or had a major operation			If yes, please explain:
Have you ever had a serious head or neck injury			If yes, please explain:
Are you taking any medication, pills, or drugs			If yes, please fill out additional form (Medication List)
Do you take, or have you taken, Phen-Fen or Redux			
Have you ever taken Fosamax, Bonivea, Actonel or any other medications containing Bisphosphonates			
Are you on a special diet			
Do you use tobacco			
Do you use controlled substances			

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other, please explain: _____

Women: are you
Pregnant/trying to get pregnant? ☐ YES ☐ NO Taking Oral contraceptives? ☐ Yes ☐ NO

Nursing? ☐ YES ☐ NO

Continued on next page

White River Dentist

Richard Schramm, D.M.D.
Tara Symancyk, D.D.S.
Mark Klampert, D.D.S.

1049 N. Hartland Road, PO Box 948
White River Jct, VT 05001-0948
802-295-2458
info@whiteriverdentist.com
www.WhiteRiverDentist.com

MEDICAL HISTORY

Do you have, or have you had, any of the following?

	YES	NO		YES	NO		YES	NO
Acid Reflux/Bulimia			Excessive Bleeding			Lung Disease		
AIDs/HIV Positive			Excessive Thirst			Mitral Valve Prolapse		
Alzheimer's Disease			Fainting/Dizzy Spells			Osteoporosis		
Anaphylaxis			Frequent Cough			Pain in Jaw Joints		
Anemia			Frequent Diarrhea			Parathyroid Disease		
Angina			Frequent Headaches			Psychiatric Care		
Arthritis/Gout			Genital Herpes			Radiation Treatments		
Artificial Heart Valve			Glaucoma			Recent Weight Loss		
Artificial Joint			Hay Fever			Renal Dialysis		
Asthma			Heart Attack/Failure			Rheumatic Fever		
Blood disease			Heart Murmur			Rheumatism		
Blood Transfusion			Heart Pacemaker			Scarlet Fever		
Breathing Problem			Heart Trouble/Disease			Shingles		
Bruise Easy			Hemophilia			Sickle Cell Disease		
Cancer			Hepatitis A			Sinus Trouble		
Chemotherapy			Hepatitis B or C			Spina Bifida		
Chest Pains			Herpes			Stomach/Intestinal Disease		
Cold Sores/Fever blisters			High Blood Pressure			Stroke		
Congenital Heart Disorder			High Cholesterol			Swelling of Limbs		
Convulsions			Hives or Rash			Thyroid Disease		
Cortisone Medicine			Hypoglycemia			Tonsillitis		
Diabetes			Irregular Heartbeat			Tuberculosis		
Drug Addiction			Kidney Problems			Tumors or Growths		
Easily Winded			Leukemia			Ulcers		
Emphysema			Liver Disease			Venereal disease		
Epilepsy or Seizures			Low Blood Pressure			Yellow Jaundice		
Have you ever and any serious illness not listed above?				YES	NO	If yes please list below		

Comments:_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent, or guardian _____ Date_____

White River Dentist

Richard Schramm, D.M.D.
Tara Symancyk, D.D.S.
Mark Klampert, D.D.S.

1049 N. Hartland Road, PO Box 948
White River Jct, VT 05001-0948
802-295-2458
info@whiteriverdentist.com
www.WhiteRiverDentist.com

MEDICATION LIST

Patient Name: _____

Address: _____

Date of Birth: _____

Healthcare Provider: _____ Telephone #: _____

Medication Name:	Dosage and Frequency:	Reason for Use:

Date: _____

White River Dentist

Richard Schramm, D.M.D.
Tara Symancyk, D.D.S.
Mark Klampert, D.D.S.

1049 N. Hartland Road, PO Box 948
White River Jct, VT 05001-0948
802-295-2458
info@whiteriverdentist.com
www.WhiteRiverDentist.com

DENTAL HISTORY

Name: _____ Date: _____

What would you like to address: _____

Date of last dental exam: _____ Previous dentist: _____

Any previous major dental treatment: ☐ Yes ☐ No When:_____Why:_____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING:

	YES	NO		YES	NO		YES	NO
Teeth sensitive to brushing or flossing			Bad Breath			Cigarettes, pipe or cigar smoking		
Bleeding gums, since when			Unpleasant taste			Bleeding gums when brushing or flossing		
Food stuck between teeth			Unfavorable dental experiences			Toothbrush, how often		
Clenching or grinding teeth			Complication from extractions			Dental floss, how often		
Burning of tongue			Periodontal treatment			Inter dental stimulators, how often		
Swelling or lumps in mouth			Orthodontic treatment			Water jet device, how often		
Frequent blisters on lips or mouth			Mouth breathing			Disclosing tables or solution, how often		
Pain around ear			Oral habits, i.e. fingernail biting, cheek biting, etc.			Fluoride supplements, how often		
Unusual sounds in ear while eating			Tender or swollen gums			Mouthwash, how often		
Teeth sensitive to hot			Tired jaw muscles			Lose or break fillings easily		
Teeth sensitive to cold			Dentures			Gag easily		
Teeth sensitive to sweets			Many cavities			Preventative dentistry		
Teeth sensitive to pressure			Many fillings			Chew on one side of the mouth		

What type of toothbrush do you use: Soft ☐ Medium ☐ Hard ☐ Nylon ☐ Natural ☐

Do you want a fluoride supplement: Yes ☐ No ☐

Do you want to be taught preventative dental hygiene: Yes ☐ No ☐

Are you unusually nervous about dental visits: Yes ☐ No ☐

Do you want to save your remaining teeth: Yes ☐ No ☐

Is there anything you would like to add: _____

_____

White River Dentist

Richard Schramm, D.M.D.
Tara Symancyk, D.D.S.
Mark Klampert, D.D.S.

1049 N. Hartland Road, PO Box 948
White River Jct, VT 05001-0948
802-295-2458
info@whiteriverdentist.com
www.WhiteRiverDentist.com

RECORDS RELEASE AUTHORIZATION

To: _____

_____

_____

I hereby authorize and request you to send:

White River Dentist
PO Box 948
White River Jct, VT 05001-0948
802-295-2458
info@whiteriverdentist.com

All dental records and x-rays in your possession, for the continuance of my/my child's dental care. Please email, if possible. Thank you.

Name: _____

Address: _____

_____

_____

Signature: _____

Date: _____

****IMPORTANT: PLEASE HAVE YOUR X-RAYS AND TREATMENT HISTORY SENT TO OUR OFFICE PRIOR TO YOUR DENTAL APPOINTMENT. DUPLICATE X-RAYS TAKEN MAY BE AT YOUR EXPENSE.**