Patient Information

Name: _____ Name of community_____

Initial____** ***Dental Insurance: For private dental insurance, payment is required up front, but I will gladly assist in filing an insurance claim for you to receive reimbursement.

Initial____** If I don't have my ***teeth cleaned every 3-6 months problems may arise. I understand that my dental treatment is important for my overall health.

Initial____** ***$165-cleaning and fluoride**. If it has been awhile since your last cleaning it may take more than one appointment.**

Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to maintain the confidentiality of your health information. This describes how we may use and disclose your protected health information to carry out treatment, payment of health care operation and for other purposes that we are permitted or required by law. We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. For example: your health/dental information may be provided to a dentist to whom you have been referred. In addition, we may disclose your protected health information periodically to another dentist, physician or health care provider who becomes involved in your care. We may use and disclose dental information about you in order to obtain payment for services rendered. Such disclosures may be made to you, an insurance company, responsible party or third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

I give consent for dental hygiene and preventive treatment for the patient
I reviewed the Privacy Practices above
Permission granted to Review of Medical Records
Permission is granted to take pictures of Patient for Chart ID.

Patient will need family intervention for… (please circle) Scheduling Treatment Plans Financial

When it is time to schedule I prefer… (please circle) Text Call Email Auto Schedule at agreed Interval

Responsible Party's Name (or POA): _____

Relationship to Patient _____

Billing Address _____

Contact Phone home #: _____ cell #_____ Text ok: Yes or No

Email: _____

***Signature of Client/Patient (Responsible Party)*_____**

***Date_____**

***The Client/Patient (or Guardian) agrees to be fully responsible for total payment of treatment performed by your hygienist**