FRESH DENTAL GROUP
Everyone Deserves a FResh Smile

PATIENT REGISTRATION

Patient Information

Address: ______________________ Address 2: ______________________

City: ______________ State: _____ Zip: _____-_____ Email: ______________________

Home #: ____________ Work #: ____________ Ext.: ______ Cell #: ____________ Preferred: ❑Cell ❑Work ❑Home

❑Male ❑Female ❑Other: __________ ❑Married ❑Single ❑Divorced ❑Separated ❑Widow

Birth Date: __________ Age: _____ Soc. Sec.: ____-____-____ Driver's License #: ______________ State: ________

Occupation: ______________________ I would like to receive correspondences via: *(check all)* ❑Email ❑Text

Employment Status: ❑Full Time ❑Part Time ❑Retired Emergency Contact: ______________________

Student Status: ❑Full Time ❑Part Time Contact Phone: ______________________

Who may we thank for referring you? ______________________ Preferred Pharmacy: ______________________

Insurance Information

Primary Insurance

Name of Subscriber: ______________________ Pt./Subscriber Relationship: ❑Self ❑Spouse ❑Child ❑Other

Subscriber DOB: ________ Employer: ______________________ Insurance Co.: ______________________

Subscriber SSN #: ______________________ Member ID.#: ______________________ Group #: ______________________

Secondary Insurance

Name of Subscriber: ______________________ Pt./Subscriber Relationship: ❑Self ❑Spouse ❑Child ❑Other

Subscriber DOB: ________ Employer: ______________________ Insurance Co.: ______________________

Subscriber SSN #: ______________________ Member ID.#: ______________________ Group #: ______________________

Although dental professionals primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that me taking, could have an important interrelationship with the dentistry you will receive. Thank you for providing the following information. Your answers will be kept confidential, subject to applicable laws.

PATIENT MEDICAL HEALTH HISTORY

Primary Physician: ______________________ Phone: ______________ City: ______________ State: ________

Specialist: ______________________ Phone: ______________ City: ______________ State: ________

❑ Cardiologist ❑Endocrinologist ❑ Orthopedist ❑ Other: ______________ Last Physical Exam: __________

Please list any current medications: ____

____

____

Do you need to be pre-medicated for dental procedures? ❑ Y ❑ N If so, what antibiotic? ______________________

How would you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Are you allergic to any of the following? Please check all that apply:

Aspirin		Penicillin		Codeine		Acrylic	
Metal		Latex		Sulfa Drugs		Local Anesthetics	
Other:							

Women, are you: ❑Pregnant ❑Trying to become pregnant ❑Nursing ❑Taking oral contraceptives

PATIENT MEDICAL HEALTH HISTORY	Yes	No	If yes, please explain:
Are you currently under the care of a physician?			
Have you ever been hospitalized or had a major operation?			
Are you on a special diet?			
Do you smoke, chew tobacco or vape?			
Do you use controlled substances?			
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			
Have you been treated with radiation or chemotherapy?			
Are you taking blood thinners?			

Do you have, or have you had, any of the following? Please check all that apply:

Rheumatic Fever		Stroke		Hepatitis A, B, or C		Visual changes	
Heart Attack		Headaches		Jaundice		Glaucoma	
Heart Murmur		Epilepsy or Seizures		Ulcers		Frequent Nosebleeds	
Heart Pacemaker		Numbness / Tingling		Kidney Disease		Sinus Problems	
Shortness of breath		Dizziness / Fainting		Venereal Disease/STD		Throat Soreness	
Congenital ❤ Defect		Psychiatric Care		Renal Dialysis		Hoarseness	
High Blood Pressure		Shingles		Sickle Cell Disease		Tonsillitis	
Artificial Heart Valve		Sleep Apnea		Anemia		Tire Easily, Weakness	
Swelling of the Limbs		Tuberculosis		Blood Transfusion		Marked Weight Change	
Heart Surgery		Emphysema		Hemophilia		Night Sweats	
Chest Pains		Asthma / Hay Fever		Low Blood Sugar		Persistent Fever	
Irregular Heartbeat		Persistent Cough		Excessive Bleeding		AIDS / HIV Positive	
Congestive❤ Failure		Difficulty Breathing		Leukemia		Drug Addiction	
Diabetes		Shortness of Breath		Rash / Hives		Cancer	
Familial Diabetes		Arthritis / Gout		Change in Skin Color		Chemotherapy	
Thyroid Disease		Artificial Joint		Anaphylaxis		Radiation Treatments	
Alzheimer's Disease		Osteoporosis		Low Blood Pressure		Tumors or Growths	

PATIENT DENTAL HEALTH HISTORY

Date of last dental exam: ______________ Date of last professional cleaning: ______________

Previous Dentist: ______________ City: ______________ State: ________

Notable dental procedures: ______________________________

I routinely see my dentist every: ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other: ______________

How often do you brush your teeth? ______________ How often do you floss your teeth? ______________

Have you ever been told you have periodontal disease (gum disease)? ☐ Yes ☐ No

Have you had, or are you currently experiencing, any of the following? Please check all that apply:

Bad Breath		Grinding Teeth		Sensitivity to Cold		Jaw Pain	
Sensitive Chewing		Sensitive Biting		Sensitivity to Heat		Loose Teeth	
Broken Teeth		Sores or Lesions		Sensitivity to Sweets		Bleeding Gums	
Discolored Teeth		Abscess		Toothache		Pain in Jaw Joint	
Dentures		Partials		Braces		Migraines	

On a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
How happy are you with your smile?	1	2	3	4	5	6	7	8	9	10

PATIENT DENTAL HEALTH HISTORY	Yes	No	If yes, please explain:
Have you ever had a bad dental experience?			
Has fear/anxiety ever stopped you from having dental treatment?			
Do you have all your teeth? If not, which are missing?			
Do you have oral habits which might affect your oral health (i.e. pipe smoking, playing musical instruments, biting fingernails)?			
Do you avoid chewing on one side of your mouth?			
Have you had complications with past dental treatment?			
Have you had trouble getting numb?			
Does food get trapped between your teeth?			
Have you ever whitened or bleached your teeth?			
Do you wear a bite appliance?			
Do you ever get fever blisters or cold sores?			
Do you have dry mouth?			
Do you drink sodas or sport drinks regularly?			
Do you chew gum, suck on hard candy or cough drops?			
Do you snore?			❑ Don't Know
Does your snoring bother other people?			❑ Don't Know

If you snore, is your snoring:
- ❑ Slightly louder than breathing
- ❑ As loud as talking
- ❑ Louder than talking
- ❑ Louder than talking, can be heard in adjacent room

How often do you snore? ❑ Nearly every day
❑ 3-4 times/week ❑ 1-2 times/week
❑ 1-2 times/month ❑ Never or nearly never

Has anyone notice that you quit breathing in your sleep?
- ❑ Nearly every day
- ❑ 3-4 times a week
- ❑ 1-2 times a week
- ❑ 1-2 times a month
- ❑ Never or nearly never

Instructions: Use the scale below to choose the most appropriate number for each situation.
0=would NEVER doze | 1=SLIGHT chance of dozing | 2=MODERATE chance of dozing | 3=HIGH chance of dozing

	Chance of Dozing
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in a public place	0 1 2 3
As a passenger in a car for an hour	0 1 2 3
Laying down in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (no alcohol)	0 1 2 3
In a car and stopped for a few minutes	0 1 2 3
Total Score	*(Add up the Numbers)* _______ / 24

What is the most important thing to you about your dental visit today? ______________________________

Why did you leave your previous dentist? ______________________________

Please rank the following in the order in which they would keep you from accepting dental treatment:

____ Fear of pain # ____ Cost of treatment #____ Lack of concern #____ Convenience

______________ Reviewed By ______ Date ______________________ Patient's Signature (Guardian) ____________ Date

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with an accurate medical history before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. Your mouth truly is connected to your health. The patient is an important part of the treatment team. It is important to report any problems or complications you are experiencing so they can be addressed by your dentist. It is equally important to report your medical conditions to us. Certain heart conditions may create a risk of serious or fatal complications. If you have a heart condition or heart murmur, high blood pressure, diabetes, pregnancy, or other health conditions, advise your dentist immediately so she/he can consult with physician if necessary.

Please inform us of all medication you are currently taking on top of any medications that you are allergic to. If you are taking oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes or if you are taking antibiotics.

As with all procedures and surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee you the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally. There are risk and limitations to all procedures. The practice of dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections.

Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

1.) Pain, swelling, and discomfort after treatment;

2.) Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist;

3.) Temporary, or, on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste;

4.) Damage to adjacent teeth, restorations or gums;

5.) An altered bite in need of adjustment;

6.) Possible deterioration of your condition which may result in tooth loss;

7.) Jaw fracture;

8.) Allergic reaction to anesthetic or medication;

9.) A root tip, bone fragment or a piece of a dental instrument may be left in your body, and may have to be removed at a later point in time;

10.) If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment;

11.) Infection in need of medication, follow-up procedures or other treatment;

12.) The need for replacement of restorations, implants or other appliances in the future;

13.) Need for follow-up care and treatment, including surgery;

14.) Prolonged numbness.

Specific Problem Examinations

In the event that a patient requests only a specific problem be addressed (i.e. broken tooth, pain in one area, etc.) this is considered a problem-focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. The dentist cannot diagnose problems in other areas of the mouth. Any future treatment of other areas will require additional x-rays and a complete exam. You will not be considered a patient of record unless this examination is completed.

Radiographs (X-Rays)

Our office takes the minimum x-rays to allow us to do a thorough exam for each patient. Modern dental x-ray equipment is extremely low dose radiation. Patient will receive a series of intra-oral x-rays. Diagnostic x-rays provide the dentists with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Without these x-rays, we cannot do a complete exam. We may also take photos of our patients as part of their permanent record. We will not release these photos to anyone without your permission.

Minor

We must receive written consent prior to performing any non-emergency procedures on a minor. Grandparents, step-parents, friends, relatives, etc. are not legally allowed to consent to dental procedures. Unless they have been given written consent by the patient or legal guardian, please do not send your child to an appointment alone or with someone else other than yourself unless you have filled out any necessary consent forms prior to the appointment. Otherwise, we may have no choice but to reschedule your child's appointment to another day.

I certify that I read and write English and fully understand this consent. PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM BEFORE SIGNING IT. By signing this form, I am freely giving my consent to allow and authorize the doctor and/or his/her associates to render any treatment deemed necessary, desirable and/or advisable to me, including the administration and/or prescribing of any anesthetic and/or medication.

______________________ Print Patient's Name

______________________ Patient's Signature (Guardian)

__________ Date

______________________ Print Name (if signed on behalf of the patient)

______________________ Relationship

FINANCIAL POLICY AND CONSENT FOR SERVICES

Thank you for choosing MyDNTST of Maple Lawn, LLC d/b/a Fresh Dental Group for your dental care. Our team is committed to your overall health and the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment.

Just as we are committed to providing you with the very best dentistry has to offer, so are we committed to making dentistry financially comfortable for you. As a condition of treatment, written financial arrangements are made in advance to ensure you understand your financial obligation. For your convenience, we accept cash, credit cards, debit cards and flex spending cards. We also have flexible payment and dental savings plans available.

INSURANCE: For those patients with dental insurance, we're happy to submit your dental claims and accept payment from your insurance company. Your insurance contract exists solely between you and your insurance carrier. We cannot be responsible for the limitations and exclusion determined by your participating insurance plan. If your insurance carrier downgrades your services or pays a lesser amount according to your coverage then you, the patient will be responsible for the remaining balance due within thirty (30) days of receiving your explanation of benefits from your insurance provider.

TREATMENT PLANS: A treatment plan estimate is a good faith attempt to predict the cost of treatment. As treatment progresses, your dentist may determine in consultation that different or additional treatment is necessary and your financial responsibility may change. Treatment estimates can only be extended for a period of six (6) months from the date treatment was recommended.

AUTHORIZATIONS

❑ **By checking this box:**

- I authorize MyDNTST of Maple Lawn, LLC d/b/a Fresh Dental Group to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.
- I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to MyDNTST of Maple Lawn, LLC or Fresh Dental Group.
- I grant permission to MyDNTST of Maple Lawn, LLC d/b/a Fresh Dental Group to: *(check all that apply)* ❑telephone ❑email ❑text me to discuss my account or treatment.
- I understand that cancellations must be at least 24-hours in advance of a scheduled appointment. The charge for single missed appointments or appointments not cancelled within 24-hours will be charged at a rate of $50 for each hour scheduled.
- I understand that interest of 5.25% per month will be added on unpaid balances over sixty (60) days; accounts over ninety (90) days delinquent will be sent to a collection agency and a collection fee of 35% of the balance will be charged to my account; a $50 charge will be added to my account for a returned check.
- I understand that it's my responsibility to notify my dentist within thirty (30) days of service if there is a problem. I also understand the through this notification, my dentist will act on my behalf to attempt to correct the problem or provide a referral to another health care practitioner. Any concerns past thirty (30) days will be the responsibility of the patient and any services provided will be an additional cost to the patient.
- I accept and agree that there are risk and limitations to all procedures. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee and/or assurance has been made by anyone regarding dental treatment that I have requested and authorized.

I CERTIFY THAT I HAVE READ AND I UNDERSTAND THE ABOVE INFORMATION. I acknowledge that all my questions have been answered to my satisfaction. You have the right to accept or deny treatment before it is performed. The fee(s) for these services have been explained to me and I accept them as satisfactory. I understand the insurance estimate is not a guarantee of payment and that I am responsible for any difference in payment. By signing this form, I am freely giving my consent to authorize Fresh Dental Group including the dentists, hygienists, and administration to use and/or prescribe anesthetic agents and/or medications. Fresh Dental Group reserves the right to change or cancel these terms and conditions at any time.

Patient Printed Name	Signature of Patient (Parent or Guardian)	Date
Witness Signature	Date	

CREDIT CARD PAYMENT AUTHORIZATION

Thank you for selecting MyDNTST of Maple Lawn, LLC, d/b/a Fresh Dental Group (the "Practice") for your dental needs. Please complete and sign this form to authorize the Practice to apply charges to your credit card listed below.

By signing this form, you give the Practice permission and authorization for your credit card to be automatically charged for (i) the remaining balance on your account, after your insurance company has paid on an outstanding claim, without prior notification; (ii) any applicable charges for membership in our Dental Savings Plan; and (iii) fees related to missed or cancelled appointments with less than 24-hour notice.

CREDIT CARD INFORMATION

Billing Address: ______________________________

City, State, Zip: ______________________________

Account Type: ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

Cardholder Name: ______________________________

Account Number: ______________________________

Expiration Date: __________ CVV (3-digit number on back of card): __________

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company so long as the transmission corresponds to the terms indicated in this form. I understand that this authorization will remain in effect until I cancel it in writing and I agree to notify the practice in writing of any changes in my account information or termination of this authorization immediately.

______________________________ Signature of Cardholder

______________________________ Date

I would like my receipt: ❑ Emailed ❑ Mailed ❑ No Receipt Necessary

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ________________________________, hereby certify that I have read the Notice of Privacy Practices ("Notice"), which is available on the website located at www.FreshDentistry.com and at the practice office. I understand that in accordance with the Health Insurance Portability and Accountability Act of 1996 (also known by its acronym, "HIPAA"), I have certain rights to privacy regarding my protected health information.

____
{Please Print Name}

____
{Signature}

____
{Date}

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ____________________ E-mail: ______________________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices ("Notice") before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact: Our office administrative team

Telephone: 443-390-2500

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the practice. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ______________________________ Date: ________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________ Date: ________________

AUTHORIZATION FORM FOR USE AND DISCLOSURE OF PATIENT INFORMATION.

By signing this form, you will consent to our use and disclosure of your protected health information for a use or disclosure of patient information that is not permitted or required by HIPAA.

Patient's Name: ____

Patient's Date of Birth: ____ Date: _________________

I hereby authorize the use and disclosure of patient information as described below. I understand that Information disclosed pursuant to this authorization may be subject to redisclosure by **redisclosure** by the recipient and may no longer be protected by HIPAA Privacy Regulations.

Specific description of the patient information to be used or disclosed:

____

Purpose(s) of this use or disclosure:

____

[If the patient or the patient's personal representative is requesting the use or disclosure, you may write "at the request of the individual" for the purpose.]

I authorize the following person(s) to make use or disclosure:

Dr. Eric Resh and/or staff member

The following person(s) may receive this patient information:

____

Right to Revoke: You will have the right to revoke this Authorization Form at any time by giving us written notice of your revocation submitted to the practice. Please understand that revocation of this Authorization Form will *not* affect any action we took in reliance on this Authorization Form before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Authorization Form.

SIGNATURE

I, have had full opportunity to read and consider the contents of this Authorization Form. I understand that, by signing this Authorization Form, I am giving my consent to your use and disclosure of my protected health information as described above.

Signature: ____ Date: _________________

If this Authorization Form is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

____

Relationship to Patient: _____

COVID-19 PANDEMIC
NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability of virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

While we're taking all necessary precautionary measures, dental procedures create water spray which is one way the disease can spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby. This may leave you vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I understand and accept the additional risk of contracting COVID-19 at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

____ ____________________

Signature of Patient, Parent, or Guardian Date

Authorization for The Use and Release of Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, MyDNTST of Maple Lawn, LLC d/b/a Fresh Dental Group (the "Practice") may not use or disclose your health information without your authorization except as provided in our Notice of Privacy Practices. Your signature on this form indicates that you are giving permission for the uses and disclosures described below.

Patient Name:____ Date of Birth: _______________

Address:____

If, other than patient, print the name of the person requesting release of dental records on behalf of the patients named above, and specify relationship to the patient.

Requestor's Name: ______________________________ Relationship to Patient: _________

Address:____

By signing below, I give permission to the Practice to release copies of (check one):

- ❑ My dental records
- ❑ My child's dental records
- ❑ The dental records of the patient named above whom I am legally authorized to represent

I authorize and request that the records to be released/sent to: (please print clearly)

Name/Dental Practice:______________________________ Email: _______________________

Address:____

Office Phone: ____________________________ Fax: ___________________________________

I understand that:

- I have the right to request a copy of this form after I sign it, as well as to inspect or copy any information to be used and/or disclosed under this authorization.
- If the person or organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

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- A copy of the patient record will be released. The original patient record remains the property of the Practice and will be maintained in accordance with Maryland state laws.

I hereby authorize and request the release of the following information:

Dental Record (Treatment Notes, Perio Charting)	**Dental X-Rays & Other Images**
❑ Last 2 Years	❑ Last 2 years
❑ Full History	❑ Full History
❑ Other (specify):	❑ Other (specify):

To request a copy of your Financial History or Treatment Plans, please contact the office.

Processing your request for copies of records and radiographs (x-rays) takes approximately ten (10) working days after receipt of the authorization form. **I understand there may be a charge for this information.**

This authorization will remain in effect for one (1) year from the date of the signature below, unless you specify a different date here: ________________(date). You or your personal representative may revoke this authorization at any time by providing written notice as specified in our Notice of Privacy Practices; however, your revocation will not apply to any previously released information.

____ ____________________

Patient/legally authorized representative signature Date

____ ____________________

Printed name if signed on behalf of the patient Relationship