Patient Registration

Date ___________________________

Gender: ☐Male ☐Female Title: ☐ None ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr.

Patient's Legal Name: ____ ___________________________

First Middle Last Preferred Name

Birthdate: ____________________ Social Security Number: ____________________ DL#/State: _____________________

Phone #'s: ____

Cell Home Work Other Cell

Home Address: ____ City, State, Zip: _____________________

E-Mail: ____

How did you hear about us? ☐ Google ☐ Insurance ☐ Internet Search ☐ Facebook ☐ Drive by ☐ Referral

☐ If other, please specify: ________________________ ☐ If referral, who may we thank? _____________________________

Other family members who are patients here: ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant Other

Appointment Preference: ☐None ☐AM ☐PM Available Short Notice: ☐Yes ☐No

The Patient Is (select **ALL** that apply): ☐ Insurance Policy Holder ☐ Responsible Party/Account Guarantor

Employed: ☐Full-Time ☐Part-Time ☐N/A Student: ☐Full-Time ☐Part-Time ☐N/A

For Emergencies, Contact: ____

Name Phone Relationship

Who is Responsible for Your Account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other

If Other, Describe Relationship to Responsible Party: ____

Responsible Party's Information

(Fill this section out if YOU yourself are not the responsible party, otherwise, skip to Signature Section

Legal Name: ____

First Middle Last

Birthdate: ______________ Social Security Number: _______________________ Phone#: __________________________

Home Address: ____ City, State, Zip: _____________________

Employer: ____

Signature: ______________________________________ Date: _____________________

Insurance Information

Date ________________________

Do you have Dental Insurance (DENTAL, not medical): ☐Yes ☐No **If no, skip** to Signatures section

Employer for Insurance: ____

Insurance Company Name: ____ ID #: _____________________

Address: ____ City, State, Zip: _________________________

Group #: ___________________________ Group Name: ____

Insurance Holder's Relation to Patient: ☐Self ☐Spouse ☐Other, specify: __________________________

If NOT self: Policy Holder First Name: ______________________ Policy Holder Last Name: _____________________

Policy Holder Birthday: ________________ Policy Holder Social Security #: ________________________

Policy Holder Address: ____

Policy Holder Phone Number: __________________________________

IF YOU HAVE SECONDARY DENTAL INSURANCE, fill out the section below **If not, skip** to Signature section

Employer for Insurance: ____

Insurance Company Name: ____ ID #: _____________________

Address: ____ City, State, Zip: _________________________

Group #: ___________________________ Group Name: ____

Insurance Holder's Relation to Patient: ☐Self ☐Spouse ☐Other, specify: __________________________

If NOT self: Policy Holder First Name: ______________________ Policy Holder Last Name: _____________________

Policy Holder Birthday: ________________ Policy Holder Social Security #: ________________________

Policy Holder Address: ____

Policy Holder Phone Number: __________________________________

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to this dental office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize use of this signature on all insurance submissions.

Signature: ______________________________ Date: ____________________

Appointment Information

Reason for your visit today: ____

____

Are you in pain? ☐Yes ☐No If yes, describe: ____

____

CHECK ALL THAT APPLY ☐ **No to all (skip to signature)**

☐Discomfort, clicking, or Popping in jaw	☐Lost / broken filling(s)	☐ Stained Teeth	☐Difficulty closing jaw
☐Red, swollen, or bleeding gums	☐Teeth grinding / clenching	☐ Locking jaw	☐Difficulty opening jaw
☐A removable dental appliance	☐ Ringing in ears	☐ Bad Breath	☐ Loose / shifting teeth
☐Blisters / sores in or Around the month	☐ Broken / chipped tooth	☐ Burning tongue / lips	☐ Gum Disease
☐Prolonged Bleeding from an injury / extraction	☐Toothache	☐Swelling / lumps in mouth	
☐ Recent infections or sore throat	☐Food caught between teeth	☐ Other	

My teeth are sensitive to (check all that apply): ☐Hot ☐ Cold ☐Sweets ☐Biting

Anything else you want to share: ____

____

Signature: ______________________________________ Date: __________________________

Medical History

Date ______________________

Patient Name: ____ **Patient Birthday:** ____________________

Are you under the care of a physician? ☐ Yes ☐ No Explain: ____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No Explain: ____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No Explain: ____

Are you taking any medications, pills, Or drugs? ☐ Yes ☐ No **List ALL Meds:** ____

____

____

(Bring with you OR attach a separate list if needed)

Do you take, or have you taken, Phen-fen or Redux? ☐ Yes ☐ No Explain: ____

Do you or have you ever taken Fosamax, Boniva, Actonel, or any other Bisphosphonate medication? ☐ Yes ☐ No Explain: ____

Are you on a special diet? ☐ Yes ☐ No Explain: ____

Do you use tobacco? ☐ Yes ☐ No Explain: ____

Do you use controlled substances? ☐ Yes ☐ No Explain: ____

Has a physician or previous dentist recommended you take antibiotic pre-medication prior to dental appointments? ☐ Yes ☐ No Explain: ____

WOMEN, are you? ☐ Pregnant/Trying to get Pregnant ☐ Nursing ☐ Taking ORAL contraceptives

---

Are you ALLERGIC to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetic

Do you have any other known allergies? ☐ Yes ☐ No If yes, please list: ______________________________

____

Continue to Page 2 of Medical History... **Dr. Initials** ☐

Ryan Dental Group * 1650 E. Stacy Road, Ste.100, Allen TX 75002 * (P) 972-727-5001 * (F) 214-644-0077 * Office@RDGAllen.com * www.RDGAllen.com

Medical History, page 2 **Do you, or have you ever, had any of the below diseases or medical conditions? If NO to ALL, check here:** ☐

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medication ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Radiation Treatment ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Arthritis / Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells / Dizziness ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Breathing Problem ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack / Failure ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers (stomach) ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble / Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Yellow Jaundice ☐ Yes ☐ No	**Anything else not listed above, explain:**		

I certify that I have read and understand the questions asked. I certify that I have answered the questions in completion and do not hold the practice, doctor(s), or team responsible for any errors or omission that I have made in completing the forms. I consent to the diagnostic procedures, including radiographs, and treatment by the dentist(s) of this office necessary for proper dental care.

Signature of Patient or Guardian: ________________________**Date:** ____________ **Dr. Initials** ☐

Supplemental Questions

Name ________________________

Has there been any change to your health over the last year? ☐ Y ☐ N **If yes, explain:** ____

Date of last general medical exam? ______________, **Doctor's Name:** ___________________________, **Phone** ______________________

Medical Alerts

Previous Infective Endocarditis?	☐ Yes	☐ No	Prescription Blood Thinner (NOT just aspirin)	☐ Yes	☐ No
Damaged heart valves in a transplanted heart?	☐ Yes	☐ No	Blood Clot History?	☐ Yes	☐ No
Unrepaired cyanotic congenital heart disease?	☐ Yes	☐ No	TIA History?	☐ Yes	☐ No
Repaired (completely) CHD within the last 6-months?	☐ Yes	☐ No	Immunocompromised?	☐ Yes	☐ No
Repaired CHD with residual defects?	☐ Yes	☐ No	Total Joint Replacement(s)?	☐ Yes	☐ No

Appointment Considerations

I want Nitrous Oxide (Laughing Gas):	☐ Always	☐ Never	☐ Unsure	☐ Sometimes depending on the procedure		
Severe Dental Anxiety?	☐ Yes	☐ No		Mental Handicap?	☐ Yes	☐ No
Generalized Anxiety?	☐ Yes	☐ No		ADD/ADHA?	☐ Yes	☐ No
No Epinephrine due to medical reasons?	☐ Yes	☐ No		Hearing Aids / Problems?	☐ Yes	☐ No
Difficulty getting numb for treatment?	☐ Yes	☐ No	☐ DK	Parkinson's?	☐ Yes	☐ No
Anesthetic wears off quickly?	☐ Yes	☐ No	☐ DK	Dry Mouth Problems?	☐ Yes	☐ No
Physical Handicap?	☐ Yes	☐ No		Jaw/TMJ Surgery History?	☐ Yes	☐ No

Sleep

Sleep Apnea Diagnosis by MD?	☐ Yes	☐ No	CPAP for Sleep?	☐ Yes	☐ No	Acid Reflux?	☐ Yes	☐ No
Snoring (NOT diagnosed as apnea?	☐ Yes	☐ No	Oral Appliance for Sleep?	☐ Yes	☐ No			

Dental Specific Allergies

Fluoride	☐ Yes	☐ No	Acetaminophen	☐ Yes	☐ No	Erythromycin	☐ Yes	☐ No
Ibuprofen	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No	None	☐ Yes	☐ No

Dental Care History

Previous Dentist Name/Contact Info………………					**Fluoride Use**		
					Is your home water fluoridated?	☐ Y	☐ N
Reason for changing dentists, if applicable………					Do you use toothpaste with fluoride?	☐ Y	☐ N
					Do you purposely avoid fluoride?	☐ Y	☐ N
Date of Last Dental Cleaning………………………….							
					History Of:		
Your Frequency of Dental Cleanings, in months.	☐ 3	☐ 4	☐ 6	☐ Other	Orthodontics/Braces?	☐ Y	☐ N
How often do you brush your teeth?					Currently wear Retainers?	☐ Y	☐ N
Manual or Electric Brush?	☐ M	☐ E	☐ Both		Oral Surgery?	☐ Y	☐ N
How often do you floss?					Dental Implants?	☐ Y	☐ N
Type of floss (string, handle, pik, waterpik, etc).					TMJ Therapy?	☐ Y	☐ N
Does food or floss catch between your teeth?	☐ Y	☐ N			Periodontal Cleanings?	☐ Y	☐ N

Cosmetics			Unfavorable past dental experience? ☐ Y ☐ N
Are you happy with your smile?	☐ Y	☐ N	If yes, explain:
Do you want to whiten your teeth?	☐ Y	☐ N	

Dentures/Partials: **Do you have a denture, complete or partial (NOT a bridge cemented over permanent teeth/roots)?** ☐ **Y** ☐ **N**

If Yes, continue below: ***If No, skip to Signature***

What date did you receive your FIRST denture?		Has your present denture ever been relined?	☐ Y	☐ N
How old is the CURRENT denture you have?		Is there a problem with your current denture?	☐ Y	☐ N

Signature of Patient or Guardian: ________________________**Date:** ____________ **Dr. Initials** ☐

Financial & Appointment Policies

PAYMENT OPTIONS
You may pay using cash, check, and most major credit cards. In the event a check is returned by your bank as unpaid due to insufficient funds or any other reason, associated fees for the failed transaction will be applied to your account and passed along as an additional financial responsibility to you.

Payment is due the day treatment is rendered. Should a balance accrue on the account, a statement will be sent, and payment is to be made, in full, by the date on the statement. If payment is not paid within 30 days, interest may be applied to the account balance. A revised statement with the new account balance, payable immediately, will be sent.

Please ask us if you are interested in learning about third party financing to help with your dental expenses.

DENTAL INSURANCE
Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. Submitting dental claims to the insurance company is a COURTESY provided by our office, not an obligation. It is the patient's responsibility to provide the office with current dental insurance information prior to appointments. Ryan Dental Group will use the information given to provide ***estimates***, but we cannot guarantee eligibility and coverage. Insurance plans vary greatly, and insurance companies do not always divulge every plan detail to us when we call. **It is ultimately the patient's responsibility to know and understand their plan**, including but not limited to network status, frequency limitations, coverage limitations, waiting periods, and benefits used at other offices.

ESTIMATES
Estimates given at Ryan Dental Group do not take into account benefits you may have used at a different provider, nor do they account for the age of any existing restoration, prosthesis, or appliance that we are replacing (some insurance companies have replacement limitations and the patient is responsible for knowing these limitations).

Estimates and treatment plans are based upon information gathered during an examination. Once treatment is begun, there may be unforeseen treatment adjustments and/or complications. Additional costs may be incurred if treatment needs change. The patient will be made aware of changes in their treatment needs.

ACCOUNT BALANCES
I agree to pay the fees for any dental care provided by Ryan Dental Group. If insurance processes and there is still a balance on my account above and beyond what was estimated, I understand that I am responsible for the balance. If insurance denies a service, I am responsible for the complete charge. Insurance's payment is subject to the terms and agreements made between the patient and their insurance company. Patients are responsible for taking up grievances related to insurance coverage or policies directly with their insurance company. Balances over 90-days may be subject to interest fees. In the event that collection procedures are necessary to collect on an account, I agree to pay collection fees incurred by the office.

APPOINTMENT CONSIDERATIONS:

CANCELLATIONS: We require at least 24 hours advanced notice from your scheduled appointment time when changing or cancelling an appointment. This allows us time to contact & schedule a patient from the waiting list into the open time slot. Failure to provide adequate cancel notice may result in a charge of $25.

NO-SHOWS: When you schedule an appointment, we reserve that time and prepare in anticipation of serving your needs. When you no-show an appointment, you hurt 3 people: yourself, the dentist/hygienist, and other patients who may be in need of care and waiting for an open appointment. Additionally, each operatory receives a custom set-up depending on the treatment needs of the individual patient. There are costs and unnecessary wastes incurred by the office associated with the set-up and tear-down/sterilization of an operatory. No-Shows are subject to a charge of $50.

LATE ARRIVALS: If you are going to be more than 10-minutes late, call our office. If the tardiness will cause other patients to not be seen on time, or will not allow the doctor/hygienist sufficient time to complete your treatment, the appointment may be cancelled. Cancellations resulting from patient tardiness will be considered a No-Show and possible subject to the $50 No-Show fee.

Patients who continue to no-show or cancel without notice may be dismissed from the practice and asked to find another dentist.

Signature: ______________________________ Date: ___________________

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement opportunities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters, email, or text).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.20 for each page, $10 per hour for staff time to locate and copy your

health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have a right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) You 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.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon request.

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 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.

Contact Officer: Laura Ryan, D.D.S **Telephone: (972)-727-500** **Fax: (214)-644-0077**
E-mail: Office@RDGAllen.com **Address: 1650 E, Stacy Rd, Suite 100, Allen, TX 75002**

CHOOSE SOMEONE TO ACT FOR YOU

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take action.

List any individual(s) below who you consent for us to share your protected health information with, including but not limited to appointment times, treatment needs, and insurance/account information:

You MAY share my info with: ______________________________
Name **Phone Number** **Relationship**

You MAY share my info with: ______________________________
Name **Phone Number** **Relationship**

Do NOT share my info with, if any: ______________________________
Name(s)

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 Contact Person listed above. 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 the Notice of Privacy Practices. I understand that, by signing this form, I am acknowledging my receipt and understanding of the Notice and I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Patient's Printed Name	**Signature of Patient/Guardian**	**Date**

😊 *The End, Thank You* 😊