

#### Patient Information

Patient name :		,	Date:	
Last	First M		Name)	
Email		Gender:	Family Status:	, , , , , , , , , , , , , , , , , , ,
Social Security #: Phone (Home):		Birth Date: _	- 11 MT	
Phone (Home):	(Work):	EXT:	Cell Phone:	
Address:Street	·············			A
Street		<u>:</u>		Apartment #
City		State		Zip Code
D.License_		Tealth Information	1	
Date of last Medical Vis				
Are you in good health:		_ 1000001101		<u> </u>
Are you now, or have you		are of a physician in t	he last 12 months?	Ves No
If so what condition is b				_100 _ 100
Physician's Name			Phone	
Have you ever been hos				,
If yes, explain			<del>-</del>	•
Have you had excessive	bleeding requiring	special treatment?	Yes No	
Do you take Aspirin dai	ly? Yes No	-	<del></del>	
Do you take Ibuprofen (	(Advil or Motrin) da	ily? Yes No		
Are you taking or have			ns (Iridia, Zometa, I	Fosamax0, etc. to you
knowledge?YesN	o	•	•	•
Are you currently taking		escribed by a doctor?	Yes No	
Are you currently taking	g any OTC (over the	counter) medication	s? Yes No	
Are you currently taking	g any medications se	elf prescribed?Yes	No No	
Are you taking any holi		r alternative suppleme	ents	•
(herbs, vitamins, minera			•	
Please list name of all n	iedications, herbs, v	itamins, their purpose	e, and dosage below	•
I		5		
2		6		
3. <u>.</u>		7. <u></u> _		
4	····	8	· · · · · · · · · · · · · · · · · · ·	
				4
Have you ever had any	_		hat apply:	
	Faint	ting	Pacem	
AIDS		coma		it Pregnant
HIV	Grov			ate:
Allergies		Feyer		ion Treatment
Anemia	Head	l Injuries:		atory Problems
Arthritis	Hear	t Disease	Rhuen	natic Fever
Artificial Joints	Hear	i Murmur	Rhuen	ıatism
Asthma	Нера	etitis		Problems
Blood Disease	High	Blood Pressure	Stoma	ch Problems
Cancer	Jaun	•	Stroke	
Diabetes	Kidn	iey Diseasc	Tubero	culosis
Dizziness		r Disease	Tumor	'S
Epilepsy	Men	tal Disorders	Ulcers	
Excessive Bleeding	Nerv	ous Disorders	CONT	INUED
_				

Venereal Disease Codeine Allergy Penicillin Allergy Tetracycline Allergy Erythromycin Allergy
Latex Allergy
Heart Valve Replacements
Stents

Bacteri	ial Endocarditis
Other:	
	<b>ተ</b> %

Date of last Dental visit? Reason for	visit?		<del></del>
Have you ever had any complications follower places explain.	owing dental treatment?		<del></del>
o Does Dental treatment make you nervous	or anxious? Yes No of Moderate Severe		
o Do you have any health problems that nee  If yes, please explain	d further clarification?	YesNo	<u>.                                    </u>
To the best of my knowledge all of the preceding a I ever have any change in my health, I will inform	the doctors at the next appoin	ided are true ar ntment without	nd correct. If fail.
Signature of patient , parent or guardian		•	
Referral	Information		•
Another patient, friendAnother patientNewspaper School Work Other Name of person or office referring you to our			
The following is for: the patient's spouse the pers	on responsible for payment	•	
Male Female	Married	SingleC	hildOthe
Social Security#:(Work):	Birth Date: Ext Best	time to call	
Address:Street		Apartme	ent#
City	State	Zip Co	ode
Employ	ment Information		•
The following is for: the patient's spouse the pers. Employer name:	Occupation		· · · · · · · · · · · · · · · · · · ·

# Insurance Information

Primary			is insu	red a patient?	~Yes	No
Name of insured:		MI				•
Last	First	متستهبر	G	гопр#		
Insured's Birth Date:	ID#			******	·	
Insured's Address:	<u></u>			_		.m
Insured's Employer Name:		<del></del>				
Address:		Spouse	Child	Othe <del>r</del>	•	
Patient's relationship to in	ısıred:Self	_ phonse		-		
Insurance Plan name and Address:			·			
Secondary			is insu	red a patient	? Yes	No
Name of insured:		ΜĪ	:	•		
Last	First □D#	7477	(	Froup#		
Insured's Birth Date:						
Insured's Address:						
l'usured's Employer Name:						
Address:		Spouse	Child	Other		
Patient's relationship to i	nsured: Self _	_ 21000			, ;	
Insurance Plan name and Address					:	•
			<del></del>			;



Patient Name\_

### PATIENT CONSENT FORM

I hereby authorize Anthony DeLucia D.D.S., P.A. and whomever he may designate as his assistants, to perform upon me the following operation and/or procedures: assistants, to perform upon me the following operation and/or procedures: EXAMS, X-RAYS, FILLINGS IF NEEDED, AND ANY PROCEDURE THAT IS NEEDED ORALLY. NEEDED, ROOT CANAL IF NEEDED, AND ANY PROCEDURE THAT IS NEEDED ORALLY. And if any unforeseen condition arises in the course of these designated operations and/or procedures calling in their judgment, for procedures in addition to or different from those now contemplated, I further request and authorize him to do whatever he deems advisable.  I consent to the above treatment plan after having been advised of the alternate plans of treatment available, the known material risks of the treatment to be used and the consequences if this treatment were withheld.  I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include postoperative bleeding, swelling, or bruising; discomfort, stiff jaw, loss or lossening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbance (e.g. numbness in the mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of feeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.  I further consent to the administration of local or general anesthesia, antibiotics, analgesics, or any other drugs that may be deemed necessary in my case, and understand that there is a slight any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of local or general anesthesia. The risk includes adverse drug response (e.g. allergic reactions) cardiac arrest, and aspiration and phrombophilabitis (e.g. irritation and swelling of a vein), pain, dis		Last	First	·Middle
And if any unforeseen condition arises in the course of these designated operations and/or procedures calling in their judgment, for procedures in addition to or different from those now contemplated, I further request and authorize him to do whatever he deems advisable.  I consent to the above treatment plan after having been advised of the alternate plans of treatment available, the known material risks of the treatment to be used and the consequences if this treatment were withheld.  I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include postoperative bleeding, swelling, or bruising; discomfort, stiff jaw, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbance (e.g., numbness in the mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.  I further consent to the administration of local or general anesthesia, antibiotics, analgesics, or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. The risk includes adverse drug response (e.g. allergic reactions) cardiac arrest, and aspiration and phrombophhlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves, which may cause by injections of any medications or drugs.  A more complete explanation of all complications of surgery and anesthesia is available to me upon my request from the Doctor.  I realize that in spite of the possible complications, my contemplated surgery/ treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees hav	assistants, to perfo	Anthony DeLucia Dorm upon me the fol	lowing obeignou grows.	probability
And if any unforeseen condition arises in the course of these designated operations and/or procedures calling in their judgment, for procedures in addition to or different from those now contemplated, I further request and authorize him to do whatever he deems advisable.  I consent to the above treatment plan after having been advised of the alternate plans of treatment available, the known material risks of the treatment to be used and the consequences if this treatment were withheld.  I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include postoperative bleeding, swelling, or bruising; discomfort, stiff jaw, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbance (e.g. numbness in the mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.  I further consent to the administration of local or general anesthesia, antibiotics, analgesics, or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. The risk includes adverse drug response (e.g. allergic reactions) cardiac arrest, and aspiration and phrombophhlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves, which may cause by injections of any medications or drugs.  A more complete explanation of all complications, my contemplated surgery/ treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.  I realize that it is mandatory that I give as accurate and co	NEEDED, ROOT	CANAL IF MEEDED	, AND ANT FROCEDO	
treatment available, the known material risks of the treatment of surgery are certain unavoidable this treatment were withheld.  I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include postoperative bleeding, swelling, or bruising; discomfort, stiff jaw, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft issues, nerve disturbance (e.g. numbness in the mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.  I further consent to the administration of local or general anesthesia, antibiotics, analgesics, or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. The risk includes adverse drug response (e.g. allergic reactions) cardiac arrest, and aspiration and phrombophhlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves, which may cause by injections of any medications or drugs.  A more complete explanation of all complications of surgery and anesthesia is available to me upon my request from the Doctor.  I realize that in spite of the possible complications, my contemplated surgery/ treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.  I realize that it is mandatory that I give as accurate and complete medical and personal history as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures.  Signature of Parient or Guardian	And if any unfores procedures calling contemplated, I fu	seen condition arises g in their judgment, f urther request and au	s in the course of these for procedures in addition uthorize him to do whate	designated operations and/or n to or different from those now ever he deems advisable.
complications. In oral surgery, the most committed to the bleeding, swelling, or bruising; discomfort, stiff jaw, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbance (e.g. numbness in the mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.  I further consent to the administration of local or general anesthesia, antibiotics, analgesics, or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. The risk includes adverse drug response (e.g. allergic reactions) cardiac arrest, and aspiration and phrombophhlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves, which may cause by injections of any medications or drugs.  A more complete explanation of all complications of surgery and anesthesia is available to me upon my request from the Doctor.  I realize that in spite of the possible complications, my contemplated surgery/ treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.  I realize that it is mandatory that I give as accurate and complete medical and personal history as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures.  Signature of Parient  Date	treatment availab this treatment we	le, the known mater re withheld.	iai fisks of the freatment	,
any other drugs that may be deemed necessary in the passion of any drug or anesthesia. The risk includes adverse element of risk inherent in the administration of any drug or anesthesia. The risk includes adverse drug response (e.g. allergic reactions) cardiac arrest, and aspiration and phrombophhlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves, which may cause by injections of any medications or drugs.  A more complete explanation of all complications of surgery and anesthesia is available to me upon my request from the Doctor.  I realize that in spite of the possible complications, my contemplated surgery/ treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.  I realize that it is mandatory that I give as accurate and complete medical and personal history as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures.  Signature of Patient  Date  Signature of Parent or Guardian	complications. In bleeding, swelling common complic nerve disturbance and swallowing of jaw which might	oral surgery, the mog, or bruising; disconstitions can include in e (e.g. numbness in raspiration of teeth require extensive su	nfort, stiff jaw, loss or lonfection, loss or injury to the mouth and lip tissue and restorations, and singery for removal.	osening of dental restorations. Less adjacent teeth and soft tissues, es), jaw fractures, sinus exposure mall root fragments remaining in the
I realize that in spite of the possible complications, my contemplated surgery/ treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.  I realize that it is mandatory that I give as accurate and complete medical and personal history as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures.  Signature of Patient  Date  Signature of Parent or Guardian  Date	any other drugs to element of risk in drug response (elements and sweet may cause by in	that may be deemed therent in the admin e.g. allergic reactions elling of a vein), pair jections of any medi	istration of any drug or a significant case, is cardiac arrest, and as a significations or drugs.	anesthesia. The risk includes adverse piration and phrombophhlebitis (e.g. y to blood vessels and nerves, which
necessary and desired by me. I am aware that the practice of deficitly exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.  I realize that it is mandatory that I give as accurate and complete medical and personal history as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures.  Signature of Patient  Date  Signature of Parent or Guardian  Date	upon my reques	t from the Doctor.		
Signature of Parent or Guardian  Date  Date	necessary and d exact science at results of the op	lesired by me. I am nd I acknowledge the eration or procedure	aware that the practice of at no guarantees have be.	peen made to me concerning the
Signature of Patient  Signature of Parent or Guardian  Date	I realize that it is possible, follow	s mandatory that I g any and all instructi	ive as accurate and con ons as directed and per	nplete medical and personal history as mit prescribed diagnostic procedures.
Signature of Patient  Signature of Parent or Guardian  Date				Date
Signature of Parent or Guardian	Signature of Pa	tient ·		•
	Signature of Do	rent or Guardian		Date
.70 रि: के हैं भेर 772 .239 और मेरे हेर्ट्र 1 COLORADO AVE., STUART, FLORIDA 34994 www.drdelucia.com ॰ en मुंध स्थापिक drdelucia.com ॰				·
	7077-• FAX-772 220 M	702 - 731 COLORADO AVI	E., STUART, FLORIDA 34994 w	ww.drdelucia.com • eாப்பூள்பிe@drdelucia.com

·Middle



### INSURANCE POLICY

Our practice understands that our patients rely on their dental insurance to help defray the cost of their dental services. We agree to investigate what the insurance can do to assist them in paying for services and to explain the limits of their policy to them. We agree to use the current ADA codes, accurately reports dates of service and keep abreast of any changes to the plan. We will be efficient in our processing of claims. We understand that our follow up process is limited to rebilling insurance companies. We will be efficient in our processing steps and to turn any unpaid claims over to the patient for payment in 60 days.

#### FINANCIAL POLICY

In order to provide excellent service, our practice must also be a successful business. This means we must charge fair fees and collect them. I understand that my dental insurance may pay less then their estimate and that I am responsible for any unpaid portion.

I am aware that I am responsible for any fee involved in collecting a past due account. This can include and not be limited to: court fees, attorney fees, and or fees from collection companies.

You can help us keep our cost down by paying for services in the following ways:

- Cash or credit cards including Visa, Mastercard, Discover, and American Express
- 2. Monthly payments with an approved Care Credit or Capital One account

Signature

Date



## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

#### And

#### Office Policies

\*\*You May Refuse to Sign This Acknowledgement\*\*

- ✓ I have received a copy of this office's Notice of Privacy Practices.
- ✓ I give my permission to send a recall appointment card to my home and office.
- ✓ I give my permission to send billing information to my home and office.
- ✓ I give permission to leave appointment, billing or dental information on my answering machine/ voice mail/email.
- ✓ I give my permission to share appointment, billing or dental information with the person named here

(Named person to share Information with.)

- ✓ So that the Dentist, Staff, and other Patients will not be inconvenienced by those who fail to keep their scheduled appointments, this office has adopted a policy of charging a fee of \$25.00 to those patients who fail to give sufficient notice (24 hours) for broken appointments.
- ✓ Patients who repeatedly break appointments will be requested to seek dental treatment at another office.
- ✓ We reserve the right to change our privacy practices as described in our Notice of Privacy Practices.

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 health care operations.

I understand and agree to the Above:

		-à
{Signature}	{Date}	a de la composição de l
		•
Personal Representative's Name	Relationship	÷
-	For Office Use Only	
We attempted to obtain written acknowledge	ment of receipt of our Notice of I	rivacy Fractices, but
acknowledgement could not be obtained because		
Individual refused to sign		
<ul> <li>Communications barriers prohibited</li> </ul>	l obtaining the acknowledgement	
<ul> <li>An emergency situation prevented ι</li> </ul>	is from obtaining acknowledgmer	at .
☐ Other ( Please Specify):		

Consent for internet Communications  Peter Name:  And Protected Name  Consent for internet Communications  Ingrating permission to the dental practice to uplead and stars confidential petident information (including account information) and other internetion of the control practice of the cont		, <u></u>	
Consent for Internet Communications  Patient Name:  Last  First  Mil Preferred Name  Last  Mil Preferred Name  Mil Preferred Name  Last  Mil Last  Mil Preferred Name  Last  Mil Last  Last  Mil Last  Last	Vallagar Bellinge B.D.S. P.A.		5-
Consent for Internet Communications  Petient Name:  Lost First Mi Preferred Name  I grant my permission to the dental practice to upload and store contidential patient information (including societar information) in the secured web site for the dental practice. I understand that, for society purposes, the site requires a user ID and and othical information) to the secured web site for the dental practice and I are responding for manifolding the society are produced as a result of password consideration. In the dental practice is dental practice and I are responding for manifolding the society of the site of password as a result of password in access and use. I also understand the dental practice is not table for any bear placed to the fact that the dental practice is not table for any bear placed to the fact that the dental practice is not table for any bear placed to the fact that the dental practice is not table for any bear placed to the fact that the dental practice is not table for any bear placed to the fact that the fact is not table for any bear placed to the fact that the fact is not table for any bear placed to the fact that the fact is not table for any bear placed to the fact that the fact is not table for any bear placed to the fact that the fact is not table for any bear placed to the fact that the fact is secured to the past to access and use the dental practice with represent and the first saling to make use of ental practices of the transfer certain to that parties. I understand the death practice with represent and the fact placed to the past to the fact that fact and the fact that the saling to make use of ental practices or to transmit certain information to that parties. I understand the death practice or to transmit certain information to that parties. I understand the death practice or to transmit certain information to death practice or the parties. I understand the death practice or to transmit certain to the parties. I understand the death practice or the parties of the parties of the		Sirik	
Consent for Internet Communications  Patient Name:  Last  First  Mi Preferred Name  Last  First  Mi Preferred Name  Internation (including account information, appointment information and efficial information) to the secured web site for the dental practice. I understand that, for security purposes, the site regimes a user 10 and apassword for access and use. I also understand the dental practice and are responsible for maintaining the sint confidentiality of any 10 and password for access and use. I also understand the dental practice is not liable for any changes, canages, or losses that may be incurred or sufficers as a result of my sasword signed to me; and that the dental practice is not liable for any changes, canages, or losses that may be incurred or sufficers as a result of my 10 and password. In understand that dental practice is not liable for any changes, canages, or losses that may be incurred or sufficers as a result of my 10 and password. In the password, any suthorization to allow another person or entity to access and use the dental practice web site with my 10 and password. I of my 10 and password, any suthorization to allow another person or entity to access and use the dental practice web site with my 10 and password. I of my 10 and password, any suthorization to allow another person or entity to access and use the dental practice web site with my 10 and password. I also understand that State and Federal Iswa, as well as estimate or thin formation to third parties. I understand the default practice will respect to printing the summary of the summary			
Consent for Internet Communications  Patient Name:  Last  First  Mi Preferred Name  Last  First  Mi Preferred Name  Internation (including account information, appointment information and efficial information) to the secured web site for the dental practice. I understand that, for security purposes, the site regimes a user 10 and apassword for access and use. I also understand the dental practice and are responsible for maintaining the sint confidentiality of any 10 and password for access and use. I also understand the dental practice is not liable for any changes, canages, or losses that may be incurred or sufficers as a result of my sasword signed to me; and that the dental practice is not liable for any changes, canages, or losses that may be incurred or sufficers as a result of my 10 and password. In understand that dental practice is not liable for any changes, canages, or losses that may be incurred or sufficers as a result of my 10 and password. In the password, any suthorization to allow another person or entity to access and use the dental practice web site with my 10 and password. I of my 10 and password, any suthorization to allow another person or entity to access and use the dental practice web site with my 10 and password. I of my 10 and password, any suthorization to allow another person or entity to access and use the dental practice web site with my 10 and password. I also understand that State and Federal Iswa, as well as estimate or thin formation to third parties. I understand the default practice will respect to printing the summary of the summary			
Consent for Internet Communications  Patient Name:  Last  First  Mi Preferred Name  Last  First  Mi Preferred Name  Internation (including account information, appointment information and efficial information) to the secured web site for the dental practice. I understand that, for security purposes, the site regimes a user 10 and apassword for access and use. I also understand the dental practice and are responsible for maintaining the sint confidentiality of any 10 and password for access and use. I also understand the dental practice is not liable for any changes, canages, or losses that may be incurred or sufficers as a result of my sasword signed to me; and that the dental practice is not liable for any changes, canages, or losses that may be incurred or sufficers as a result of my 10 and password. In understand that dental practice is not liable for any changes, canages, or losses that may be incurred or sufficers as a result of my 10 and password. In the password, any suthorization to allow another person or entity to access and use the dental practice web site with my 10 and password. I of my 10 and password, any suthorization to allow another person or entity to access and use the dental practice web site with my 10 and password. I of my 10 and password, any suthorization to allow another person or entity to access and use the dental practice web site with my 10 and password. I also understand that State and Federal Iswa, as well as estimate or thin formation to third parties. I understand the default practice will respect to printing the summary of the summary	<b>地名美国地名英国</b>		
Patient Name:  Last  First  MI Preferred Name  Ignart my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web aits for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, or losses that may be incurred or suffered as a result of password assigned to me; and that the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password. If my ID and password, my estimated to a lidow another person to entity to access and use the dental practice will my ID and password.  I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to platent confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I tridestand the dental practice will represent and transmit that they will, at all times chring the terms of the Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or warms that they will, at all times chring the terms of the Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or warms that they will, at all times chring the terms of the Agreement and thereafter, comply with a laws directly or indirectly applicable that may now or warms that they will be applied to the subject of the subj	6-13-4-10-5		
Patient Name:  Last  First  MI: Preferred Name  I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, or losses that may be incurred or suffered as a result of password assigned to me; and that the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure my failure to maintain contidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password. In or my ID and password, my disclosure my failure to maintain contidentiality in a strict of any other need to describe the my ID due to security concerns also agree to immediately notify the dental practice of any unantificated use of my ID or of any other need to describe my ID due to security concerns. I also understand that State and Federal laws, as well as efficial and licensure requirements impose obligations with respect to platient confidentiality that limit the shifty to make use of certain services or to transmit certain information to third parties. I understand the dental practice will tree my IT of the three whire, the terms of the Agreement and thereafter, comply with all laws directly or information, and use the hours of the shift by will, at all times during the terms of the Agreement and thereafter, comply with all laws directly or information, and use the host first in the second process of the strict in the second process of the strict in the second process of the second process of the strict in cause all persons or entities under the dental practice will use commercially reasonable ef			
Patient Name:  Last  First  MI: Preferred Name  I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, or losses that may be incurred or suffered as a result of password assigned to me; and that the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure my failure to maintain contidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password. In or my ID and password, my disclosure my failure to maintain contidentiality in a strict of any other need to describe the my ID due to security concerns also agree to immediately notify the dental practice of any unantificated use of my ID or of any other need to describe my ID due to security concerns. I also understand that State and Federal laws, as well as efficial and licensure requirements impose obligations with respect to platient confidentiality that limit the shifty to make use of certain services or to transmit certain information to third parties. I understand the dental practice will tree my IT of the three whire, the terms of the Agreement and thereafter, comply with all laws directly or information, and use the hours of the shift by will, at all times during the terms of the Agreement and thereafter, comply with all laws directly or information, and use the host first in the second process of the strict in the second process of the strict in the second process of the second process of the strict in cause all persons or entities under the dental practice will use commercially reasonable ef		iternet Communications	. :
I grant my permission to the dental practice to upload and store confidential patient information (including account information) appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password assigned to me; and that the dental practice is not liable for any changes, damages, or losses that may be incurred or suffered as a result of password assigned to me; and that the dental practice is not liable for any changes, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any changes, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any changes, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any changes, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice with my iD and password. In the password, or my authorization to allow an another present or entity to access and use the dental practice with my iD and password. If the sufficient is incurred to the dental practice will represent and interesting the tental practice of any unauthorized use of my other need to decidivate my iD due to security concerns.  I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to pritter the dental practice will represent and theretains, or my pritter that the will, at all times during the tental practice of my pritting password. In the dental practice will be admitted the dental practice will be admitted by a sufficient password. In the dental practice of MINTA AND DES and the confidentiality of all patient information to the web site for the		• :	
I grark my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I site understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password as signed to may and that the dental practice is not liable for any changes, damages, or losses that may be incurred or suffered as a result of password as signed to make any that metaled to the theth of my ID and password, my disclosure my failure to maintain confidentiality. I understand the dental practice is not liable for any changes, damages, or losses that they the ID and password, my disclosure my failure to maintain confidentiality. I understand the dental practice is not liable for any changes, damages, or losses that they then the password any disclosure my ID and password, my disclosure my ID and password, or my actinorization to allow another period to entity to access and use the dental practice with my ID and password. If of my ID and password, my disclosure my ID due to security oncorans.  I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to pitiant confidentiality of make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice or certain to the parties of the dental practice will represent any the password of the dental practice or certain services, and is acting or my behalf in ploading my monitor, retrieve, store, uplead and use my information in connection with the operation of such services, and is acting in material practice. CAINOTA AND DOS AND AND TASSUME	Deficit Name		
and dirtical information; in the security will be dental practice and I are responsible for maintaining the subconditional and password, and password in social to any charges, damages, or losses that may be incurred or suffered as a result of password assigned to me; and that the dental practice is not liable for any charges, changes, or losses that may be incurred or suffered as a result of password, and password, or my authorization to allow another person or entity to access and use the dental practice was site with my ID and password. I of my ID and password, or my authorization to allow another person or entity to access and use the dental practice was site with my ID and password. I of my ID and password, or my authorization to allow another person or entity to access and use the dental practice will represent and storage to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deachivate my ID due to security concerns, also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deachivate my ID due to security concerns.  I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to plattern confidentiality of the tendent of the state of the password of the dental practice will represent and that the third the dental practices of this Agreement and the third parties. In the dental practice will represent and that the dental practice will represent and the third that the dental practice will use or my least in unlocated and use my information in connection with the operation of such services, and is acting on my behalf in uploading my months, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in understand the dental practice Cannot And Does Not Assumble Any Responsibility For My Use is uploaded to the web site on my behalf in understand the dental practice of patient.  I have r	1	First	
I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.  Signature of patient, parent, or guardian:  Date:  Relationship to Patient:	my failure to maintain contideritiality. I understand the another person my ID and password, or my authorization to allow another person also agree to immediately notify the dental practice of any unauthorization agree to immediately notify the dental practice of any unauthorization agree to immediately notify the dental practices or to transmit that limit the ability to make use of certain services or to transmit warrant that they will, at all times during the terms of this Agreem hereafter govern the gathering, use, transmission, processing, rebest efforts to cause all persons or entities under their direction of monitor, retrieve, store, upload and use my information in connepatient information. I understand the dental practice will use con is uploaded to the web site on my behalf. I understand the dental of MISI ISE OF PATIENT INFORMATION OR OTHER INFORMATION OR	an or entity to access and use the dental practice were site with my norized use of my ID or of any other need to deactivate my ID due to and licensure requirements impose obligations with respect to patter certain information to third parties. I understand the dental practice certain information to third parties. I understand the dental practice ment and thereafter, comply with all laws directly or indirectly applications and thereafter, comply with all laws directly or indirectly application, reporting, disclosure, maintenance, and storage of my information to comply with such laws. I agree that the dental practice control in comply with such laws. I agree that the dental practice control with the operation of such services, and is acting on my behavior with the operation of such services, and is acting on the behavior with the operation of such services.	security concerns.  ent confidentiality  will represent and ble that may now or nation, and use their has the right to if in uploading my tient information that
Signature:  Relationship to Patient:		e secured uploading of patient information to the web on to securely upload my patient information to the we	site for the dental eb site.
Signature:  Relationship to Patient:	signature of nations, parens, or guardian:		
Relationship to Patient	•	Date:	
	Signature:		
	Relationship to Patient		
Response Date:			
	A	Response Date:	
			:
		· · · · · · · · · · · · · · · · · · ·	•
		·	
			1