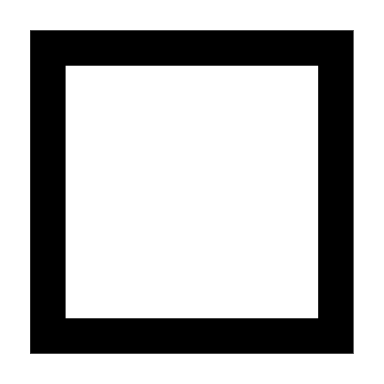
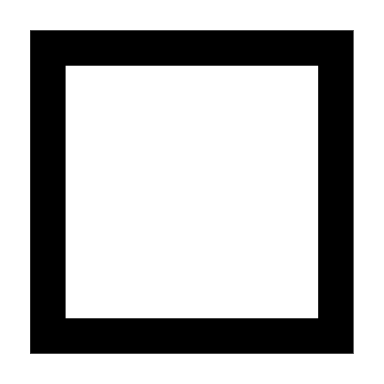
PATIENT INFORMATION

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Telephone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can receive text messages YES NO

Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for the visit \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who may we thank for referring you**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_ Telephone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FINANCIAL INFORMATION

DENTAL INSURANCE (Primary)

Insured’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Telephone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DENTAL INSURANCE (Secondary)

Insured’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Telephone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*We ask that you realize we do not work for an insurance company. Rather, we work 100% for our patients. We feel insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge will always be based on your individual needs, not your insurance coverage.*

*Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of the changes, it is not always possible. It is your responsibility to know your individual coverage. You are responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company. Not between the insurance company and your dentist. Payment, copays and deductibles are required at the time of service. If for any reason insurance does not pay, payment will be expected from the patient. A returned check fee of $50 will be assessed on all returned checks. Delinquent accounts will be assessed all collection, legal and administrative costs to the fullest extent of the law.*

**I accept and understand the patient’s responsibilities outlined above.**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL HISTORY ***Please circle any of the following that you have had or presently have***

Heart Attack

Heart Failure

Heart Disease

High Blood Pressure

Angina Pectoris

Heart Pacemaker

Blood Transfusion

Stroke

Anemia

Hemophilia

Diabetes

Sickle Cell Disease

Heart Surgery

Heart Murmur

Scarlet Fever

Rheumatic Fever

Artificial Heart Valve

Mitral Valve Prolapse

Congenital Heart Lesions

Artificial Joints (Hip, Knee)

Rheumatism

Arthritis

Kidney Disease

Thyroid Disease

Sinus Trouble

Cortisone Medication

Allergies or Hives

Hay Fever

Asthma

Emphysema

Cough

Tuberculosis (TB)

AIDS  
HIV Positive

Liver Disease

Hepatitis A

Hepatitis B

Hepatitis C

Yellow Jaundice

Nervousness

Psychiatric Treatment

Epilepsy or Seizures

Fainting or Dizzy Spells

Drug Addiction

Ulcers

Fever Blisters

Cold Sores

Bruise Easily

Phen-Fen Treatment

Cosmetic Surgery

Venereal Disease

Glaucoma

Food Allergies? If yes, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer? If yes, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did you receive Radiation or Chemotherapy? (Circle)

Are you allergic or have you reacted adversely to any of the following? (Circle all that apply)

Penicillin/Amoxicillin

Erythromycin

Tetracycline

Percodan

Sleeping Pills

Local Anesthetic

Novocain/Xylocaine

Scopolamine

Aspirin

Darvon

Codeine

Demerol

Valium

Nitrous Oxide

Latex

Other Antibiotics

Other drugs or medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking or using medication for: (Circle those that apply)

Diabetes (Pills/Shots)

Nerves

Sleeping Trouble

High Blood Pressure

Heart Disease

Blood (Liver/Iron Pills)

Stomach Trouble

Headaches/Migraines

Arthritis

Periodontal Disease

Blood Thinners (Anticoagulants)

Seizures (Dilantin)

Thyroid

Hormones (Including Birth Control)

Allergies

Please list ALL Medications you are currently taking (including over the counter, vitamins, minerals & herbal supplements)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you taking or have you previously taken Bisphosphonates? YES NO**

**These include: Fosamax Aredia Didronel Zometa Skelid Actonel Bonefos**  **Boniva**

Have you been a patient in a hospital during the past two years? YES NO 

If yes, what for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use: Cigars Cigarettes Pipe Marijuana Tobacco Chew Vaping (Circle) YES NO

If yes, do you currently use them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Frequently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many packs/day? \_\_\_\_\_\_\_\_\_\_\_

Following injuries, have you ever had bleeding problems? YES NO

Do injuries/cuts take longer to heal now than previously? YES NO

Have you recently lost weight unintentionally? YES NO

Is there a history of diabetes in your family? YES NO

Do you urinate more than 6 times a day? YES NO

Are you currently pregnant? YES NO

Are you currently on a doctor prescribed diet? If yes, for what reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

Have you been treated for alcoholism or chemical dependency? YES NO

Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Medical Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DENTAL HISTORY

Date of last dental visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental cleaning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dentist Telephone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you require premedication prior to dental visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your most important dental concern you would like addressed?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Are you having pain or discomfort currently? YES NO

Have you come to our office for relief from pain? YES NO

If yes, have you been in pain for more than 3 weeks? YES NO

If yes, where is the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have unreplaced missing teeth? YES NO

If yes, why have you not replaced them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have difficulty swallowing? YES NO

Do your gums bleed when brushing your teeth? YES NO

Have you been told you have periodontal disease? YES NO

Is any part of your mouth sensitive to temperature or pressure? YES NO

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does food catch between your teeth? YES NO

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any serious trouble associated with previous dental treatment? YES NO

If yes, briefly describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any pain or soreness around the eyes or ears? YES NO

Do you have any unpleasant taste or odor in your mouth? YES NO

Do you ever get cold sores or canker sores? YES NO

Do you ever feel that you have a dry mouth? YES NO

Are you dissatisfied with your teeth or their appearance? YES NO

Does it seem you always have something to be treated when you visit a dentist? YES NO

In the past, have you required a lot of dental work? YES NO

Have you ever had a bad experience in the dental office? YES NO

If yes, briefly describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you feel about going to the dentist? (Circle the best answer) No Problem Apprehensive Scared

OCCLUSAL SCREENING

**How do you feel about your teeth?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear complete and/or partial dentures? YES NO

If yes, upper, lower or both? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, how long have you worn dentures? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, are you unhappy with your dentures YES NO

Would you like to know more about permanent replacements? YES NO

Have you had any Periodontal (gum) treatments? YES NO

Have you worn braces on your teeth (orthodontics)? YES NO

Are you aware of any problems with snoring? YES NO

Would you like your smile to look better or different? YES NO

Have you ever been diagnosed with sleep apnea? YES NO

Have you ever been diagnosed with TMJ/TMD? YES NO

Do you have discolored teeth that bother you? YES NO

Do you regularly use dental floss? YES NO

Do you wear a bite splint/night guard? If yes, how frequently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

Are you aware of grinding or clenching your teeth? YES NO

Are you unhappy with the appearance of your teeth? YES NO

Do you have chronic headaches, earaches or neck pains? YES NO

Have you ever experienced an inability to move your jaw or open widely? YES NO

Which side of your mouth do you chew on? (Circle) Right Left Both

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize payment directly to Hometown Dental otherwise payable to me for the services as described, realizing that I am responsible to pay for non-covered services.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Hometown Dental to release any information relating to my treatment for insurance purposes, including radiographs, clinical notes and study models.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE  
By signing this form, you acknowledge that Hometown Dental has given you a copy of its’ Privacy Notice, which explains how your health information will be handled in various situations.  
Check all that are true:  
[ ] I have received a Hometown Dental Privacy Notice.  
[ ] Hometown Dental has given me the chance to discuss my concerns and questions about the privacy of my health information.  
[ ] I wish to place the following restrictions on the use and/or disclosure of my personal health  
information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I (or the minor patient) may need during diagnosis and treatment with my informed consent. I understand I am responsible for payment of services at the time they are rendered.

I hereby authorize the Hometown Dental team to take photographs, slides, intraoral photographs and/or videos of my face, jaws, and teeth. I understand that the photographs, slides and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, videotapes, DVDs television), and professional publications (dental magazines and journals). I further understand that if photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs and materials.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTICE OF HEALTH INFORMATION PRACTICES  
This notice describes how information about you may be used and disclosed and how you can get access to this information when necessary. Please review it carefully. Hometown Dental, we are committed to treating information about you and your health responsibility. This notice of health information practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protective health information. This notice is effective December 13, 2021, and applies to all protected health information as defined by federal regulations.

**Understanding Your Health Record and Information**  
Each time you visit Hometown Dental a record of your visit is made. Typically, this record contains your symptoms, examination, diagnoses, treatment, lab results and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:  
➢ A basis for planning your care and treatment  
➢ A means of communication among many health professionals who contribute to your care  
➢ A legal document describing the care you received  
➢ A means by which you a third party payer can verify that services were actually provided to obtain payment for services  
➢ A tool in educating health professionals  
➢ A source of data for medical research  
➢ A source of information for public health officials  
➢ A source of data for our planning and marketing  
➢ A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who may access your health information, and make more informed decisions when authorizing disclosure to others.

**Your Health Information Rights**  
Although your health record is the physical property of Hometown Dental, the information belongs to you. You have the right to:  
➢ Inspect and copy your health record  
➢ Amend your health record  
➢ Obtain an accounting of disclosures of your health information  
➢ Request communications of your health information by alternative means or at alternative locations  
➢ Request a restriction on certain uses and disclosures of your information  
➢ Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

**Our Responsibilities**

Hometown Dental is required to

➢ Maintain the privacy of your health information  
➢ Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you  
➢ Abide by the terms of this notice  
➢ Notify you if we are unable to agree to a requested restriction  
➢ Accommodate reasonable requests you may have to communicate health information by alternative means or at alternate locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization. For more information or to Report a Problem. If you have any questions and would like additional information, you may contact our office Hometown Dental 1250 Byron Road Howell MI 48843 (517) 546-3330.