Dental Record History

Oftentimes it is necessary to obtain your complete dental history in order to devise a treatment plan that will properly address all your immediate and long term dental needs. This consent gives our office permission to obtain those records on your (or your dependents) behalf.

Patient Name_____ DOB_____

Previous Dentist Name_____

Address _____

City_____ State _____ Zip_____

I authorize Total Smiles of Durham to request and receive any and all previous dental or medical charting as they pertain to the above named patients dental health and treatment.

_____ DOB _____ /_____/ _____

Print Name of patient or Legal Guardian

_____ _____

Signature of Patient or Legal Guardian Date

All patents over the age of 18 ***MUST*** sign their own forms. Patients under the age of age of 18 **CAN NOT** sign for themselves. ***ONLY*** a parent or a ***legal*** guardian may sign for a patient under the age of 18. (***Legal Guardian*** = you are the biological parent of the minor ***or*** you have been granted custody ***or*** guardianship over this minor by the courts.)

This consent will remain in effect for as long as I or my dependents are patients of record.

Authorization for Release of Protected Health Information
Health Information Communication Methods (HIPAA RELEASE)

We can only disclose your protected healthcare information under the terms of the HIPAA polices. If you wish to grant any person besides the patient or responsible party listed on our patient information forms to have access to your protected health information please indicate below.

Patient Name _____ DOB_____

Responsible Party_____(Parent or Legal Guardian)

RECORDS

Check all that apply	Type of Health Information
	Dental Treatment Records
	Medical Records
	Appointment Records
	Insurance Records
	Referral Records
	Billing Statements
	Contact Records

TO

Name	Relationship to Patient

COMMUNICATION

Please indicate the forms of communication that are acceptable to use for the patient, responsible party, or any persons indicated for release. Anyone you listed in the above section to release information to needs to be listed in this section. Only fill in the information asked if you are consenting to contact the person by the means indicated.

Name	**Address**	**Cell Phone**	**Home Phone**	**Work Phone**	**Email Address**	**Please list preferred method of contact**

Do we have permission to leave a message on home/cell voicemail for numbers listed? *Yes* ☐ *No* ☐

Do we have permission to leave a message on work voicemail for numbers listed? *Yes* ☐ *No* ☐

EXPIRATION

	This authorization has no expiration unless I provide a written termination request as well as sign and date a new authorization form
	This authorization will expire on

_____ _____

Signature of Patient or Responsible Party Date

I, _____ Hereby authorize

(PLEASE PRINT CLEARLY)

Total Smiles of Durham to release the Protected Health information and utilize indicated methods of communication as specified above.

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