

**3720 NW 43rd St, Suite 102**

**Gainesville, FL 32606**

**352-372-3600**

**PATIENT INFORMATION**

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as thoroughly as you can. If you have questions we’ll be glad to help you. We look forward to working with you in maintaining your dental health.

**PATIENT INFORMATION**

Date: Phone: Cell:

Name: Soc. Sec. #

 (Last name) (First Name) (Middle Initial)

Address: City: State: Zip: \_\_\_\_\_\_\_\_

Sex: [ ]  Male [ ]  Female Age: \_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide your e-mail address if you wish to receive information from us about future promotions, newsletters, education materials, etc.:

Patient’s e-mail address:

[ ]  Married [ ]  Widowed [ ]  Single [ ]  Separated [ ]  Divorced [ ]  Partner [ ]  Minor

Patient Employer/School: Occupation:

Emergency Contact: Phone:

Please provide the name of any person or persons you wish to grant permission to Premier Dental Team the ability to discuss person, insurance, financial, or dental treatment plan information with (i.e., spouse, parent, guardian, other relative, etc.)

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

Whom may we thank for referring you?

****

**PRIMARY DENTAL INSURANCE**

Person responsible for account:

 (Last Name) (First Name) (Middle Initial)

Relation to patient: Birthdate: Soc Sec #:

Address (If different from patient): City:

State: Zip: Phone:

Person Responsible Employed By: Occupation:

Insurance Company: Member #:

**INSURANCE AUTHORIZATION**

I certify that I, and/or my dependent(s), have insurance coverage with and assign directly to Premier Dental Team 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 authorize use of my signature on all insurance submissions. Premier Dental Team may use my health care information and disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

 Signature of Patient, Parent, Guardian, or Personal Representative Date

**PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED**

|  |
| --- |
| **ADDITIONAL INSURANCE**Person Responsible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Last Name) (First Name) (Middle Initial)Relation to Patient: Birthdate: Soc Sec # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address (If different from patient’s): City: State: \_\_\_\_\_\_\_\_ Zip: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Person Responsible Employed By: Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Company: Member #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



**DENTAL HISTORY**

Reason for today’s visit: Date of last dental care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Former Dentist: Date of last dental x-rays:

Check if you have had problems with any of the following:

[ ]  Bad Breath [ ]  Bleeding Gums [ ] Clicking or Popping Jaw [ ]  Food Collection Between Teeth

[ ]  Grinding Teeth [ ]  Loose or Broken Fillings [ ] Periodontal Treatment [ ]  Sensitivity to Cold

[ ]  Sensitivity to Hot [ ] Sensitivity to Sweets [ ] Sensitivity to Biting [ ] Sores or Growths in your mouth

How often do you floss? How often do you brush?

**MEDICAL HISTORY**

Physicians Name: Date of Last Visit:

1. Have you ever taken any of the group of drugs collectively referred to as “fen-phen?” These include combinations of Lonomin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine). [ ]  Yes [ ]  No
2. Do you currently (or have you in the past) taken any Bisphosphonates (e.g. Boniva, Fosamax, Actonel)?[ ] Yes [ ] No
3. Have you had any serious illnesses or operations? [ ]  Yes [ ] No If yes, describe:
4. Have you had a blood transfusion? [ ]  Yes [ ] No If yes, give approximate dates:
5. (Women) Are you Pregnant? [ ]  Yes [ ] No - Nursing? [ ]  Yes [ ] No - Taking Birth Control? [ ]  Yes [ ] No

**Check if you have had problems with any of the following:**

[ ] Anemia [ ] Cortisone Treatments [ ] Hepatitis [ ] Scarlet Fever

[ ]  Arthritis/Rheumatism [ ]  Cough, Persistent [ ] High Blood Pressure [ ] Shortness of breath

[ ] Artificial Heart Valves [ ] Cough up blood [ ] HIV/AIDS [ ] Skin rash

[ ] Artificial Joints [ ] Diabetes [ ] Jaw Pain [ ] Stroke

[ ] Asthma [ ] Epilepsy [ ] Kidney Disease [ ] Swelling of feet

[ ] Back Problems [ ] Fainting [ ] Liver Disease [ ] Thyroid Problems

[ ] Blood Disease [ ] Glaucoma [ ] Mitral Valve Prolapse [ ] Tobacco Habit

[ ] Cancer [ ] Headaches [ ] Pacemaker [ ] Tonsilitis

[ ] Chemical Dependency [ ] Heart Murmur [ ] Radiation Treatment [ ] Tuberculosis

[ ] Chemotherapy [ ] Heart Problems [ ] Respiratory Disease [ ] Ulcer

[ ] Circulatory Problems [ ] Hemophilia [ ] Rheumatic Fever [ ] Venereal Disease



 MEDICATIONS ALLERGIES

List Medications you are currently taking: List allergies you have below:

**MEDICAL HISTORY FORM AUTHORIZATION**

Please provide your signature below to indicate you have completed this medical history form to the best of your knowledge and ability and have provided Premier Dental Team accurate and thorough information regarding your medical history and contact information. We are required to ask you to update this form once every 12 months.

Signature of Patient, Parent, Guardian, or Personal Representative Date

**Financial Policy**

 Welcome to Premier Dental Team Center for Implant, Cosmetic and Reconstructive Dentistry.  Our goal is to offer state of the art treatment at an affordable investment leading to improved oral health.  Prior to seeing the doctor, a qualified clinical professional from our team will review your information and have a general conversation with you regarding your health.  This is intended to assist in the collection of data for the doctors to arrive at the correct diagnosis and treatment recommendation.  More specifically, he or she will introduce you to our practice and will assist in answering any preliminary questions you may have and obtain dental records. The rendering provider will subsequently discuss all relevant diagnostic information, make treatment recommendations, and review treatment options with you. This process may take more than one visit, as at the Premier Dental Team, we strive to provide patients with all treatment options available and excellent patient education.

**Courtesy Insurance Filing Service**:
We base our recommendations on the needs of our patients rather than the limitations of dental benefits plans.  As a courtesy to you, we will file your claims for all services with your dental benefit plan company. In order to assist in the navigation of the insurance reimbursement you are eligible for, most insurances require diagnostic records to establish the need for treatment. Most of this information must be obtained prior to providing your estimated cost for treatment. We ask that you communicate to us whether you are comfortable with moving forward towards diagnostic work up data collections irrespective of the dental insurance coverage. Since coverage rules change often, we advise you to acquaint yourself with your insurance policy and to call your insurer regarding any coverage questions.  We will always work with you to do the best for your health and wellbeing, and we look forward to sharing the benefit of our years of experience with you.

**Administrative appointment**At the Premier Dental Team, we are sensitive of patients having long waits. Should there be a need for additional records and/or verifying dental benefit coverage, our team will communicate with you regarding the urgency for care and appoint you to see an administrative team member who will assist you in navigating financial arrangement options. This appointment will be made for you unrelatedly of your clinical procedures with the rendering provider. Please provide payment at the administrative appointment for all procedures decided upon. For your convenience, we accept Visa, MasterCard, Discover, American Express, Check or Cash.  We offer extended financing through CareCredit and The Lending Club.  Surgical appointments require payment in full upon scheduling your appointment. Procedures that require the fabrication of a dental device by the laboratory must be paid in full prior to engaging into the fabrication of the dental device by the laboratory.

**Fees**:                                                                                                                                                     One total fee will be estimated, which may be divided into multiple treatment phases.  This fee includes: the consultation; all routine visits needed during the normal course of treatment; routine post-treatment check-ups.  Any circumstances requiring additional procedures, extra diagnostic methods may be subject to additional charges.  A charge will be assessed for additional appointments resulting from failure to show for a scheduled appointment, without a 48 hour prior notification.  A fee up to $65 will be assessed on all returned checks.  The guarantor agrees that any account that must be turned over to a collection agency will pay an additional minimum fee of $45, up to 40% of balance due.

**Missed Appointments**:                                                                                                                                    If you cannot keep your scheduled appointment, please let us know at least 48 hours in advance.  We make every effort to provide prompt care to all of our patients.  Appointments cancelled or missed without proper notice are subject to a $100 fee.  If you have a special circumstance regarding your missed appointment, please contact our Office Manager.  If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival.  Any significant delay may require the visit to be rescheduled.

Thank you for choosing Premier Dental Team as your dental care provider.  We sincerely desire to treat our patients in a pleasing and congenial atmosphere and find this can best be accomplished when a clear understanding exists regarding financial arrangements.  Please contact the office at any time with questions regarding your financial responsibility.

I acknowledge I have read and understood the above dental insurance information.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance Information**

As a courtesy to our patients, we are happy to file insurance claims on your behalf.  We will make every reasonable effort to collect proposed covered amounts from your insurance company to reimburse our patients for out of-pocket costs.
**Payment is due at the time of service**.

At Premier Dental Team, our only contract concerning your dental health is with you.  We will perform a thorough, comprehensive exam to determine your needs.  We are dedicated to helping you understand your current level of dental health, your treatment choices and the consequences of those choices.  Once you have that information, you can choose what is best for you.  Because our obligation is only to you, once you have made your treatment choices, there will be no compromise in rendering it.  Regardless of the type of plan you participate in, we will still assist you in filing your claims.  As your dental healthcare advocates, we will provide any documentation required to your dental plan so that you may receive the re-imbursement you are entitled to.  We are however, powerless to influence plan benefits negotiated between your employer and the insurance company.

**Please be advised, we do NOT participate with any insurance networks**.  Our first and only priority is our patients and the quality of care, not the negotiation of benefits between the insurance company and your employer.  Dental insurance plans have become more restrictive and the maximum limits set in place in the 1970’s are mostly the same today!  Limitations in coverage can take many forms. From simply excluding necessary services altogether to what the industry refers to as the “LEAT” clause, which stands for “least expensive alternative treatment”.  This clause allows the company to choose to pay the cheapest alternative treatment that they consider adequate rather than newer, technologically superior services.  Benefits were once determined based on need, they are now based on specific contract terms between an employer and the insurance carrier.  In plans that direct you to specific dentists, there is also a contract containing specific agreements between the insurance company and the dentist.

**The patient/guarantor is responsible for all charges incurred.**

I acknowledge I have read and understood the above dental insurance information.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Model Release**

Effective as of the date show below, approval for past use and permission for present and future use is being granted to Premier Dental Team to use photographs, videos, or other images taken  (the photographed party), as more fully explained in this consent and release.  The photographed party is an adult and is fully authorized to sign this consent and release.

For value received, receipt of which is hereby acknowledged, the photographed party hereby grants consent to Premier Dental Team, it’s agents, employees, licensees, and successors in interest (collectively, the released party) and authorize the use of any and all photographs taken of me, and any reproduction of them in any form in any media whatsoever and in any derivative work based thereon throughout the world, and to use them to publicize, promote and advertise, including but not limited to use for point of sale advertising.

The photographed party also consents to the use of my own name or any fictitious name which may be chosen in connection with the aforesaid photographs.

The photographed party hereby releases any and all claims whatsoever in connection with the use of my photograph and name and reproduction thereof as aforesaid.

The photographed party hereby waived any right that I may have to inspect and/or approve the book or the advertising copy that may be used in connection therewith or the use to which it may be applied.

THE PHOTOGRAPHED PARTY WARRANTS THAT (S)HE IS THE UNDERSIGNED AND THAT (S)HE HAS READ THIS CONSENT AND RELEASE PRIOR TO THE SIGNING OF THIS DOCUMENT, THAT THE UNDERSIGNED UNDERSTAND IT, AND THAT THE UNDERSIGNED FREELY ENTERS INTO THIS CONSENT AND RELEASE.

I acknowledge I have read and understood the above model release information.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Covid-19 Recommendations**

Dear Premier Dental Team Patient,

Centers for Disease Control and Prevention (CDC) recommends using additional infection prevention and control practices during the COVID-19 pandemic, along with standard practices recommended by the Florida Department of Health and the American Dental Association as a part of routine dental healthcare delivery to all patients.

These practices are intended to apply to all patients, not just those with suspected or confirmed SARS-CoV-2 infection.

      In that order, please when making your reservation for dental care, have in consideration the following instructions:

1.    Our team needs your full name, phone number, email address, updated medical history including list of medications, recent x rays and the date of your last dental hygiene procedures to update and/or establish your records.

2.    If you have been sick in the last 14 day, do not feel well TODAY or you have symptoms of COVID-19, please consider the option to reschedule your appointment. The symptoms are:

* Fever or chills
* Cough
* Shortness of breath or difficulty breathing
* Fatigue
* Muscle or body aches
* Headache
* New loss of taste or smell
* Sore throat
* Congestion or runny nose
* Nausea or vomiting
* Diarrhea

This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19.

3.    If you recently traveled (less than 14 days ago) or have come into contact  with someone with COVID-19 or if you do not wear a mask in public although that is your right, your dental visit reservation must be pre-planned by our clinical team for safety reasons.

4.    If you comply with the last requirements, please continue to give us this information to reserve your clinical appointment by completing the pre onboarding process.

Once you are confirmed to an appointment, please acknowledge:

* When you arrive, if you see someone inside the building or in transit to the waiting room, please wait in your car and come in afterwards keeping social distance.
* Even if you do not have symptoms of COVID-19, we recommend still put on your own cloth face covering before entering the facility and throughout their stay in the facility.
* Patients may remove their **cloth face covering** when in their rooms but should put it back on when around others (e.g., when visitors enter their room) or leaving their room.
* Patients may know the importance of performing **hand hygiene** immediately before and after any contact with their facemask or cloth face covering.
* When possible, **physical distancing** (maintaining 6 feet between people) is an important strategy to prevent SARS-CoV-2 transmission.
* We encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets, email, etc. (Tele dental health).
* Respiratory Hygiene/Cough Etiquette is required.

As a community, we are learning to adapt to the current climate to offer our patients and clinical team the best experience.

Thanks for choosing our Premier Services,

Dr. Ada Parra

**Covid-19 Pre-Screen Form**

1. Are you experiencing ANY of the following emergency symptoms: severe shortness of breath and difficulty breathing, persistent chest pain or pressure, new confusion or inability to arouse, bluish lips or face, loss of consciousness, slurred speech, and/or severe, constant dizziness or lightheadedness?
* Yes
* No
1. Are you experiencing any of the following symptoms? Please select all that apply.
* Fever, chills or sweating
* New or worsening cough
* Fatigue
* Body aches
* Diarrhea
* Reduced sense of smell and/or taste
* Mild to moderate difficulty breathing
* Sore throat
* Runny nose
* None of the above
1. Have you been told by a health official that you may have been exposed to COVID-19 (coronavirus)?
* Yes
* No
1. Have you been around someone who is known to have COVID-19 (coronavirus)?
* Yes
* No
1. Have you been tested before for COVID-19?
* Yes
* No
1. In the last 14 days, have you been in an area of high-risk for COVID-19 (coronavirus)?
* Yes
* No
1. In the last 14 days, have you traveled internationally?
* Yes
* No
1. In the last 14 days, have you traveled on a cruise ship?
* Yes
* No
1. In the last 14 days, have you been around someone who recently traveled to a high-risk area and is also sick?
* Yes
* No
1. Do you live or work in a care facility? (This includes a hospital, emergency room, other medical setting, or long-term facility.)
* Yes
* No
1. Over the last 14 days, have you and the people you live with been practicing social distancing of 6 feet or more?
* Yes
* No
1. Over the last 14 days, have you or the people you live with congregated with groups of more than 10 people?
* Yes
* No
1. COVID-19 (coronavirus) affects various ages differently. How old are you?
* Yes
* No
1. Do you have any of the following? Please select all that apply.
* Asthma
* Cancer
* Diabetes
* Extreme obesity
* Heat disease
* High blood pressure
* Kidney disease
* Liver disease
* Lung disease
* None of the above
1. COVID-19 (coronavirus) can affect people who have weaker immune systems from things like chemotherapy, HIV/AIDS, organ transplant, being pregnant, or prolonged steroid use. Do you have a weakened immune system from a known cause?
* Yes
* No

**Pre-Onboarding Reservation**

1. The reason for your dental appointment has been shared with our team

Yes

No

1. Medical history update has been completed

Yes

No

1. X-rays from your previous office have been requested and fulfilled if applicable

Yes

No

1. The date of your last professional teeth cleaning has been shared with our team

Yes

No

1. Failed appointments constitute: Appointments cancelled with less than 48hrs notice and no show. Please understand our clinical team is responsible for setting the operatory, verifying benefits from various dental insurance plans, making special dental supplies available as well as devoting qualified professional personnel highly trained to take care of your dental needs.

No charge will be assessed for appointments cancelled with more than 4hrs notice. Your reservation has been confirmed by the clinical team by providing a credit card to be placed on file. An authorization to charge your card is granted for failed appointments in the amount of $100.

Yes

No

1. Credit Card number
2. Credit Card expiration date
3. Credit Card CVV

**COVID-19 PANDEMIC DENTAL TREATMENT**

**NOTICE AND ACKNOWLEDGEMENT OF RISK**

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

Patient’s Name Date of Birth

The World Health Organization has characterized the COVID-19 virus, also known as “Coronavirus,” as a pandemic. Our practice wants to ensure you are aware of the risks of exposure to COVID-19 associated with receiving treatment during this pandemic.

COVID-19 is highly contagious and has a long incubation period. You or your healthcare providers may have the virus, not show symptoms and yet still be highly contagious. COVID-19 can result in a life-threatening respiratory disease in some patients. You may be exposed to COVID-19 at any time or in any place. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures can create fine water spray or “aerosols” which may remain in the air for several minutes to hours. These aerosols may contain the COVID-19 virus and may create a risk of COVID-19 exposure. You cannot wear a protective mask over your mouth to reduce exposure during treatment as your healthcare providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

To provide a safe environment for our patients and staff, this practice follows the applicable state and federal regulations and protocols for infection control, universal personal protection, and disinfection. However, due to the nature of the procedures we provide, it may not be possible to maintain social distancing between patients, doctors, and staff at all times. We have implemented teledentistry practices which involve pre-onboarding prior to your arrival into the clinic. We intend to be prepared to provide dental services in a predictable and safe manner by appointing you with your provider and single attending personnel and minimizing multiple points of contacts with other team members not directly related to your dental care. Our office reserves the right to make these decisions based on coordinated administrative and clinical efforts.

**Patient Acknowledgement**

I acknowledge that I have read the Notice above and that I understand and accept that there is an increased risk of COVID-19 exposure with treatment during the pandemic.

I understand and accept the increased risk of COVID-19 exposure with treatment at this office.

I also acknowledge that I could, or may have, exposure to COVID-19 from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

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

Patient or Legal Representative Signature Date

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

Print Patient or Legal Representative Name/Relationship

**PATIENT ACKNOWLEDGEMENT –TELEHEALTH CONSULTATION SERVICES**

Telehealth includes the use of remote communication technology to conduct virtual problem-focused evaluations to help manage oral health concerns and to determine whether immediate in-office dental treatment is required.

I have been informed that telehealth is an option during the COVID-19 pandemic to evaluate my dental health concerns, screen for dental emergencies and minimize the risk of virus transmission.

**Patient Acknowledgement – Telehealth Consultation Services**

I acknowledge that I wish to receive telehealth consultation services.

I understand that this telehealth consultation is for the purpose of evaluating dental pain, oral swelling, and / or treatment planning.

I understand that I may request to refuse or stop telehealth services at any time.

I understand that if at any time during or after the telehealth consultation I experience a life-threatening condition or medical emergency, I will immediately call 911 or go to the nearest emergency room.

I understand and accept that a telehealth consultation cannot replace an in-office consultation and I acknowledge that the doctor’s ability to diagnose my condition could be limited by this technology. I further understand, acknowledge and accept that a virtual evaluation may not reveal conditions that might otherwise be discovered during an office visit.

I agree to provide detailed and accurate information as requested by the doctor and that this information may include photographs or videos taken by me with a mobile device.

I understand that telehealth carries technology risks and that there may be an interruption in service or lack of audio/visual quality.

I understand that the telehealth consultation may be recorded for clinical documentation and quality assurance purposes.

I understand that based on the telehealth consultation, follow up treatment may be indicated.

**Patient Acknowledgement – Patient Privacy, HIPAA, and Administrative Matters**

I understand that all electronic medical communications carry some level of privacy risk for the security of my health information and I understand that my doctor and my doctors staff will use good faith efforts to protect the privacy of my health information and to minimize these risks.

I understand that during the COVID-19 national public health emergency the federal government announced that it will not enforce HIPAA regulations (regarding the privacy of health records) in connection with medical and dental offices’ good faith provision of medical or dental services using non-public facing audio or video remote communications services.

I agree to follow any technology instructions provided by the doctor for the telehealth consultation including the use of applications that allow video chats such as FaceTime, Facebook Messenger video chat, Google Hangouts, or Skype.

**PATIENT ACKNOWLEDGEMENT –TELEHEALTH CONSULTATION SERVICES**

I acknowledge that the telehealth consultation may involve requests for photos or videos taken with my mobile device and transmitted to the dental office through unencrypted applications.

I understand that I am responsible for any payment resulting from this consultation that is not covered by a dental insurance plan.

My typed or hand written name below acknowledges I that have read and understand this document, that I understand the information provided to me by the doctor and/or staff, and that my questions have been answered to my satisfaction.

Patient’s Name Date

Legal Guardian’s Name (if required) Date