NEW SMILES DENTAL

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CONSENT FOR X-RAYS

The standard of care in our office includes the use of dental radiographs (x-rays). The most common type of x-rays we will take are Full mouth X-ray and Bitewings, those x-rays are helpful in screening both upper and lower jaws and help diagnose the following:

- Evaluation of missing teeth/ Wisdom teeth
- Orthodontic considerations
- Periodontal conditions (gum and bone disease)

* Evaluation of health of tooth, roots, crowns, bridges and Implants
* Abscesses (infections) within the bone associated with teeth or otherwise
* Defects and malignancies of the bones and jaw.

These x-rays are usually part of your normal dental hygiene/examination appointments and are necessary to provide the level of diagnosis and care we strive for. At the time of your appointment our staff will notify you if you are due to have x-rays taken. If you have questions or concerns, please feel free to ask any of our staff members. We value you as a patient and take pride in providing you with optimum dental care.

Patient Name _____ Date_____ Patient Signature: _____

REFUSAL OF X-RAYS (ONLY IF YOU REFUSE TO HAVE X-RAYS TAKEN)

I have read and understand the above radiograph policy. At this time, I am choosing to refuse the x-rays that have been recommended to me. **I understand that in so choosing, my dental/oral health conditions cannot be completely evaluated and diagnosed**. This may endanger my dental/oral health as well as my overall health. Understanding this, I do not hold New Smiles Dental or any of his staff members liable or accountable for problems that may go undetected because of this decision.

PATIENT NAME _____ DATE; _____ SIGNATURE: _____

HIPAA CONSENT FORM

The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations and describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility and a copy is available at my request. **New Smiles Dental** reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:
ANY MEMBER OF MY IMMEDIATE FAMILY : YES_____ NO_____ (Spouse, Daughter, Parent)
OTHER (Please specify) _____ YES_____ NO_____ (Friend, etc..)
I ACCEPT TO RECEIVE COMMUNICATIONS VIA EMAIL AND/ OR TEXT MSG? YES _____ NO _____

_____ _____ _____

PATIENT NAME DATE PATIENT SIGNATURE