Chestnut Dental Name: _____Date of Birth: _____

ACKNOWLEDGEMENT OF PRIVACY POLICIES Part 1. Notice of privacy practices:

I have read the office's posted Notice of Privacy Practices and agree to this policy to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 and regulations. I grant the right of the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health care professionals and may be used and disclosed for treatment, payment, or healthcare operations. In the space below, list any family member we CAN share information with:

Name: _____

Name: _____

Name: _____

Name: _____

Sign here for Parts 1 ➔ X _____ Date _____

Signature of ☐ Patient or ☐ Guardian _____ Date _____

EMERGENCY CONTACT

Name: _____

Relationship_____

Emergency Contact Phone # _____

Alt Phone # _____

Do we have permission to call EMS on your behalf? ☐Yes ☐No

Hospital Preference: _____

AUTHORIZATION FOR IMAGING Part 2. I hereby authorize this office to take photographs, slides, 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, television), and professional publications (dental magazines and journals). I further understand that if the 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.

Sign here for Parts 2 ➔ X _____

Signature of ☐ Patient or ☐ Guardian _____Date_____