Santa Teresa Smiles
COSMETIC & FAMILY DENTAL

Date_____

I hereby authorize the release of my x-rays/ written records or copies of any pertinent information from;

Previous Dental Office:_____

Address _____

Dentist Phone Number:_____

Please Mail to: Santa Teresa Smiles

103 Livingston Loop Ste B3

Santa Teresa, New Mexico 88008

Or Email to: info@stsmiles.com (.JEP) Thank You.

Patient Name:_____Date of Birth:_____

Patient Signature:_____

***Please send as soon as possible! Thank you!**

OFFICE NOTICE/POLICY

TREATMENT

I am aware that treatment will be rendered by licensed Dentists and/or Hygienists.
I understand that my treatment will be provided according to the availability of the practitioner.
I will make known any diseases, allergies, or unusual reactions to drugs or medicines that have occurred to me in the past.
If my health or medications change, I will inform the Doctor/Hygienist at my next appointment without fail.
As the parent, I will be responsible for signing treatment consent forms ***prior*** to my child's treatment.

PAYMENT POLICY

I understand that unless otherwise arranged, payment for professional service is required ***on the day*** treatment is rendered.

TESTS, PROCEDURES

I may be asked for consent to the use of photographs, x-rays, impressions and/or other laboratory diagnostic tests when they are indicated for the purpose of diagnosing and planning treatment.
I may be asked for consent to the use of local anesthetic and other methods of pain control to make me more comfortable while receiving dental treatment.

RECORDS

I understand that all original dental records, x-rays, and diagnostic aids are the property of the MVFD and cannot be removed or sent from MVFD. Copies will be provided upon request of a Dentist or Physician, there will be a $35.00 charge for all duplications of records.

I ACKNOWLEDGE THAT I HAVE READ THE ABOVE INFORMATION.

SIGNATURE

_____ Date_____

Patient or responsible party (age18 or older)

HIPPA PRACTICE ACT

Notice of Privacy Practices

I also acknowledge that I have the opportunity to read, or have read a copy of **Notice of Privacy Practices**.

Patient Name (Printed) _____

Patient/Parent/Guardian Signature _____Date_____

INSURANCE COMPANY INFORMATION

Person Responsible for Account _____

(Print) Parent if child under 18 years old

Address_____City_____State_____Zip_____

Employer_____Phone_____

Primary Dental Insurance

Primary insured person name: _____ Birth Date _____
SS#_____Occupation_____Employer_____
Insurance Company_____ Phone _____
Contract #_____Group #_____Subscriber # _____
Relationship to patient_____

Additional Dental Insurance

Primary insured person name: _____ Birth date_____
SS#_____Occupation_____Employer_____
Insurance Company_____ Phone _____
Contract #_____Group #_____Subscriber # _____
Relationship to patient_____

Medical Insurance Coverage (if your plan has basic dental coverage)

Primary insured person name: _____ Birth date_____
SS#_____Occupation_____Employer_____
Insurance Company_____ Phone _____
Contract #_____Group #_____Subscriber # _____
Relationship to patient_____

Authorization

I certify assignment of insurance benefit payments to Dr. Borham, 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 Dr. Borham to submit health/dental care information to above named insurance company/companies and their agents for the purpose of obtaining payment for services and/or determining benefits for related services.

Printed Patient Signature _____
(Parent if child under 18)

Patient/Parent Signature_____ **Date** _____