



Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.

Pillsbury Dental Associates

125 Greentree Dr., Dover, Delaware 19904
www.Pillsburydentalassociates.com

(302) 734-0330
FAX (302) 734-5712

Patient Information (CONFIDENTIAL)

SS#/SIN _____
Date _____

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Email _____ Cell Phone _____

Check Appropriate Box Minor Single Married Divorced Widowed Separated
If Student, Name of School/College _____ City _____ State _____ Full Time Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parents/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License# _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? Yes No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Personal Check Credit Card Visa MasterCard I want to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____
DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING
Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

OVER PLEASE

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

		Yes	No			Yes	No
1.	Are you under medical treatment now?.....	<input type="checkbox"/>	<input type="checkbox"/>	10.	Are you wearing contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... If yes, please explain _____	<input type="checkbox"/>	<input type="checkbox"/>	11.	Are you allergic to or have had any reactions to the following? Local Anethetics (e.g. Novocain).....	<input type="checkbox"/>	<input type="checkbox"/>
3.	Are you taking medication(s) Including non-prescription medicine?..... If yes, what medication(s) are you taking? _____	<input type="checkbox"/>	<input type="checkbox"/>		Penicillin or any other Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you ever taken Fen-Phen/Redux?.....	<input type="checkbox"/>	<input type="checkbox"/>		Sulfa Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates?.....	<input type="checkbox"/>	<input type="checkbox"/>		Barbiturates.....	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you taken Viagra, Revatio, Cialis or Levitra In the last 24 hours?.....	<input type="checkbox"/>	<input type="checkbox"/>		Sedatives.....	<input type="checkbox"/>	<input type="checkbox"/>
7.	Do you use tobacco?.....	<input type="checkbox"/>	<input type="checkbox"/>		Iodine.....	<input type="checkbox"/>	<input type="checkbox"/>
8.	Do you use controlled substances?.....	<input type="checkbox"/>	<input type="checkbox"/>		Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>
					Any Metals (e.g. nickel,mercury,etc.).....	<input type="checkbox"/>	<input type="checkbox"/>
9.	Do you have or have you had any of the following?				Latex Rubber?.....	<input type="checkbox"/>	<input type="checkbox"/>
		Yes	No		Other(please list).....	<input type="checkbox"/>	<input type="checkbox"/>
	High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	12.	Do you have a persistent cough or throat clearing not associated with a known illness(lasting more than 3 weeks)?.....	<input type="checkbox"/>	<input type="checkbox"/>
	Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>		Thank 3 weeks)?.....	<input type="checkbox"/>	<input type="checkbox"/>
	Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>		13. Women Only:		
	Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>		a.) Are you pregnant or think you may be pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
	Fainting/Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>		b.) Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>
	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>		c.) Are you taking oral contraceptives?....	<input type="checkbox"/>	<input type="checkbox"/>
	Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>				
	Epilepsy/Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>		Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
	Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>		Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>		Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>
	Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>		Angina.....	<input type="checkbox"/>	<input type="checkbox"/>
	AIDS or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>		Frequently Tired.....	<input type="checkbox"/>	<input type="checkbox"/>
	Thyroid Problem.....	<input type="checkbox"/>	<input type="checkbox"/>		Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
					Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>
					Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
					Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>
					Joint Replacement.....	<input type="checkbox"/>	<input type="checkbox"/>
					Hepatitis/Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
					Sexually Transmitted Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
					Mitral Valve Prolapse... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Stomach Troubles/Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
					Other.....	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

		Yes	No			Yes	No
1.	Do your gums bleed while brushing or flossing?.....	<input type="checkbox"/>	<input type="checkbox"/>	8.	Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>
2.	Are your teeth sensitive to hot or cold liquids/foods?.....	<input type="checkbox"/>	<input type="checkbox"/>	9.	Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
3.	Are your teeth sensitive to sweet or sour liquids/foods?.....	<input type="checkbox"/>	<input type="checkbox"/>	10.	Do you bite your lips or cheeks frequently?.....	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you feel pain to any of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	11.	Have you ever had any difficult extractions in the past?.....	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you have any sores or lumps in or near your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	12.	Have you ever had any prolonged bleeding following extractions?.....	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you had any head, neck or jaw injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>	13.	Have you had orthodontic treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you ever experienced any of the following problems in your jaw? Clicking.....	<input type="checkbox"/>	<input type="checkbox"/>	14.	Do you wear dentures or partials?.....	<input type="checkbox"/>	<input type="checkbox"/>
	Pain (joint, ear, side of face).....	<input type="checkbox"/>	<input type="checkbox"/>	15.	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....	<input type="checkbox"/>	<input type="checkbox"/>
	Difficulty in opening and closing.....	<input type="checkbox"/>	<input type="checkbox"/>	16.	Do you like your smile?.....	<input type="checkbox"/>	<input type="checkbox"/>
	Difficulty in chewing.....	<input type="checkbox"/>	<input type="checkbox"/>				

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnoses and the records of any treatment or examination rendered to me or my child during the period of such Dental care to the third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient (or parent/guardian if minor) Date

<i>Doctor's Comments</i> _____ _____ _____ _____ _____
<i>Signature</i> _____ <i>Date</i> _____



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APPOINTMENT GUIDELINES

Minimizing appointment cancellations and "no-shows" is a major goal of every dental practice. Achieving this goal allows us to operate more effectively and to provide timely, high quality care to our patients. Every time a patient unexpectedly misses an appointment that time is potentially denied to another patient.

Patients who find it necessary to cancel or reschedule should give us at least 48 business hours notice (weekends and holidays excluded). If you have to cancel or reschedule, we would prefer it if you would call us in person rather than leave a message on our answering machine.

Eligibility for care may be affected for patients who repeatedly (2 or more times in a 6 month period) cancel, reschedule, or miss appointments. Patients who repeatedly have appointment attendance problems, no show for scheduled appointments, or cancel with less than 48 business hours notice may also be subject to a \$75.00 fee or discontinuation from the practice. The \$75.00 fee is to be paid prior to scheduling another appointment.

Patients who fail their initial appointment with us without properly canceling or rescheduling are no longer eligible for patient care in our practice.

We are not unreasonable and recognize that there will always be valid reasons for rescheduling. Our goal is to minimize appointment disruptions which is beneficial to our patients as well as our practice.

The parent or a responsible adult should remain here while minor children under their supervision are being treated. We often have to get permission from the "adult in charge" to do certain procedures on the child. Also, if an emergency would arise, it is best that the adult be present.

Please do not bring small children or infants to your dental appointments. We do not have babysitting capabilities.

We appreciate the opportunity to work for your dental health and your cooperation with the above policies.

Patient: _____

Date: _____



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Authorization to take Photographs

I hereby authorize photographs to be taken in connection with my dental treatment.

I understand that photographs will be used to more thoroughly document my case, to assist in diagnosis and treatment planning, to document need for certain types of treatment to insurance carriers, and for promotional/advertising and educational purposes.

Please initial the appropriate box below:

I authorize intraoral (mouth and teeth) photos only.

I authorize full face photos as well as intraoral photos.

Patient Signature: _____ Date: _____

James S. Pillsbury, D.D.S.

125-2 Greentree Dr.

Dover, Delaware 19904

Phone: (302) 734-0330

Fax: (302) 734-5712

We want to make the care you need and deserve affordable to you and therefore offer the following options for payment:

- For your convenience, we accept the following means of payment:
 - Major credit cards: Visa, Master Card, American Express, Discover

 - Care Credit- a unique loan program offering interest- free payment plans as well as interest-baring plans, requires a credit application. Ask our financial coordinator about these plans.

- A 5% discount for payment in full IN ADVANCE for services over \$400.00, for cash only payments, no credit cards, and insurance can not be applied.

We look forward to being able to provide you with the dental care you need. If you have any questions please feel free to ask our financial coordinator. You may contact us at anytime during our normal business hours.

We are glad you are with us!

Patient Signature: _____ Date: _____



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SIGNATURE AUTHORIZATION FORM

I have reviewed the following treatment plan. I authorize the release of any information relative to this claim.

Signature (patient or parent if minor)

Date

I hereby authorize payment of my group insurance benefits, otherwise payable to me, to the dentist listed below.

Signature (insured person)

Date



Pillsbury Dental Associates

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Dover, DE 19904

(302) 734-0330

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INSURANCE GUIDELINES:

We are committed to providing you with the best possible care. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of the following:

- Dental Insurance seldom covers the entire cost of the treatment and is only intended to offset your cost of care
- Dental Insurance often delays, denies, or underpays estimated benefits.
- Dental Insurance often does not cover proven treatments which are necessary and in your best interests.

•YOUR INSURANCE BENEFIT IS A CONTRACT BETWEEN YOUR EMPLOYER, THE INSURANCE COMPANY, AND YOU. We are NOT a party to that contract. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

If you have dental insurance, we are happy that you have this benefit to assist you with your dental care, and we will do everything we can to help you make your care as cost effective as possible by working with your benefit plan.

However, in view of the above, you acknowledge and agree to be responsible to our office for the total of any fees charged prior to any insurance considerations.

Patient Signature: _____ Date: _____

Pillsbury Dental Associates

HIPAA NOTICE OF PRIVACY PRACTICES

(“Notice”)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Dental Practice Covered By This Notice

This Notice describes the privacy practices of Pillsbury Dental Associates (“Dental Practice”). “We” and “our” means the Dental Practice. “You” and “yours” means our patient.

How to Contact Us/Our Privacy Official

If you have questions or would like further information about this Notice, you can either write to or call the Privacy Official for our Dental Practice:

Dental Practice Name:	Pillsbury Dental Associates
Privacy Official for Dental Practice:	Holly Haniffee
Dental Practice mailing address:	125-2 Greentree Dr Dover, DE 19904
Dental Practice email address:	office@pillsburydentalassociates.com
Dental Practice phone number:	(302) 734-0330

Information Covered By This Notice

This Notice applies to health information about you that we create or receive and that identifies you. This Notice tells you about the ways we may use and disclose your health information. It also describes your rights and certain obligations we have with respect to your health information. We are required by law to:

- maintain the privacy of your health information;
- give you this Notice of our legal duties and privacy practices with respect to that information; and
- abide by the terms of our Notice that is currently in effect.

Our Use and Disclose of Your Health Information Without Your Written Authorization

Common Reasons for Our Use and Disclosure of Patient Health Information

Treatment. We will use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

Payment. We may use and disclose your health information to obtain payment from health plans and insurance for the care that we provide to you.

Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

Appointment Reminders. We may use or disclose your health information when contacting you to remind you of dental appointment. We may contact you by using a postcard, letter, voicemail, or email.

Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

Less Common Reasons for Use and Disclosure of Patient Health Information

The following uses and disclosures occur infrequently and may never apply to you.

Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medication or foods; reporting product defects; enabling product recalls; notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to be appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

Law Enforcement Purposes. We may disclose patient health information to a law enforcement official for a law enforcement purpose, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

Coroners, Medical Examiners and Funeral Directors. We may disclose patient health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

Organ, Eye and Tissue Donation. We may disclose patient health information to organ procurement organization or others to obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

Research Purposes. We may disclose patient health information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

Serious Threat to Health or Safety. We may use or disclose patient health information if we believe it is necessary to do so to prevent or lesson a serious threat to anyone's health or safety.

Specialized Government Functions. We may disclose patient health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

Workers' Compensation. We may disclose patient health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information

We will make other use and disclosures of health information not discussed in this Notice only with your written authorization. You may revoke that authorization at any time in writing. Upon receipt of the written revocation, we will stop using or disclosing your health information for the reasons covered by the authorization going forward.

Your rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPPA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

Access. You may request to review or request a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

Amend. If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

Restrict Use and Disclosure. You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception. If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

Confidential Communications: Alternative Means, Alternative Locations. You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information for the six years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPPA). The first accounting we provide in any 12-month period will be without charge to you. We will charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

Receive a Paper Copy of this Notice. You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

We Have the Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice (including any updates) is in the top right-hand corner of the Notice.

To Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with U.S. Department of Health and Human Services Office of Civil Rights.

The privacy of your health information is important to us. We will not retaliate against you in any way if you choose to file a complaint.

Pillsbury Dental Associates
ACKNOWLEDGEMENT OF RECEIPT OF
HIPPA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPPA Notice or Privacy Practices**.

Patient Name (Please Print)

Patient Signature

Date

OR

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

- Parent Guardian Power of Attorney Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- ___ An emergency prevented us from obtaining acknowledgement.
- ___ A communication barrier prevented us from obtaining acknowledgement.
- ___ The individual was unwilling to sign.
- ___ Other: _____

Staff Member Signature

Date

Pillsbury Dental Associates

**HIPPA AUTHORIZATION FOR REALEASE OF
PROTECTED HEALTH INFORMATION**

(“Authorization”)

By signing this Authorization, you agree to the release of your Protected Health Information as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPPA Privacy Rules. If you have questions about this Authorization, please contact the Privacy Official for the Dental Practice, noted below. If you agree with this Authorization, please complete it, sign and date it at the end and provide to us.

Our Dental Practice contact information

Dental Practice Name:	Pillsbury Dental Associates
Privacy Official for Dental Practice:	Holly Haniffee
Dental Practice mailing address:	125-2 Greentree Dr Dover, DE 19904
Dental Practice email address:	office@pillsburydentalassociates.com
Dental Practice phone number:	(302) 734-0330

Your contact information

Patient Name:	
Patient mailing Address:	
Patient e-mail address: (optional)	
Patient phone number:	

Protected Health Information that I am authorizing the Dental Practice to release (please check the records to which this Authorization applies):

I authorize the Dental Practice named above to release the following Protected Health Information:

Dental Reports

Dental Image(s)

All dental records relating to (specify injury or illness):

Other (specify)

The reason for the release of the Protected Health Information (please check the reason(s) that apply:

Patient Request

Review Patient's current health

Treatment/continued care

Payment for care, including insurance

Legal

Obtaining Social Security Disability or other public benefits

Other (specify): _____

I am requesting that the Dental Practice release my Protected Health Information to (please complete):

Organization name:	
Personal name or title:	
Mailing address:	
Phone number:	

If you want your Protected Health Information to be provided to the organization/person by e-mail, please provide the e-mail address:

If you want your Protected Health Information to be provided to the organization/person by fax, please provide the fax number:

When your Protected Health Information is released as provided in this Authorization, the recipient may not have a legal obligation to protect its confidentially and may redisclose it.

Expiration of this Authorization:

This Authorization will automatically expire one year after the date that I sign it unless I (the patient) indicate an earlier date or event here:

Your rights with respect to this Authorization:

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization.

If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to the Dental Practice to the address or e-mail address indicated on the first page of this Authorization. The revocation will not have any effect, however, actions taken in reliance on the Authorization prior to your revocation.

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

Patient Signature

Date

OR

Signature or Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

- Parent Guardian Power of Attorney Other:

Informed Consent
For
Local Anesthesia (Injections)

The advantage of local anesthesia (shots, needles) is pain-free dental treatment. We emphasize that complications from local anesthesia are extremely rare, but complications can and do occur and may include but are not necessarily limited to the following:

1. Needle Tract soreness in soft tissues, usually does not last for more than 24 hrs.
2. Hematoma, swelling or bruising of the facial soft tissues, usually resolves by itself with no permanent effects.
3. Partial or Total numbness, may or may not resolve.
4. Pain upon biting on a tooth, this can occur with intra-ligamentary injections which are given right beside the tooth to be anesthetized. This normally resolves in a few days but can take longer to resolve.

We emphasize that pain-free dental treatment cannot be provided without local anesthesia and that complications from local anesthesia are extremely rare. This is a routine procedure.

I have read and understand the above and give my consent for local anesthesia. All my questions have been answered.

Patient/Parent/Guardian Signature

Date: _____