Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**. I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)

Obtaining payment from third party payers (e.g. my insurance company)

The day to day **healthcare operations** of your practice.

I have also been informed of and given the right to review and secure a copy of your ***Notice of Privacy Practices*** which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand I may revoke this consent ***in writing*** at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ____ day of _____, 20___

Print patient name: _____

Relationship to patient: _____

Signature: _____

Sweetwater Dentistry
5915 Sweetwater Circle
Fairhope, AL 36532

Smile Evaluation

1. Do you like the way your teeth look? YES or NO
2. Are you happy with the color of your teeth? YES or NO
3. Would you like for your teeth to be whiter? YES or NO
4. Would you like for your teeth to be straighter? YES or NO
5. Do you have spaces between your teeth that you would like to close? YES or NO
6. Do you like the shape of your teeth? YES or NO
7. Would you like your teeth to be longer? YES or NO
8. Do you have missing teeth you would like to replace? YES or NO
9. Do you have silver fillings you would like to replace with porcelain fillings? YES or NO
10. If you could change anything about your smile, what would you change?

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