TIDEWATER
DENTAL ARTS

Tidewater Dental Arts strictly follows HIPAA guidelines to protect your health information. By signing this form, I understand that a copy of the office's Notices of Privacy Practices is available for my review and I am agreeing to the information presented in the Notice of Privacy Practices.

Our office meets or exceeds all infection control standards set forth by OSHA, the CDC, and the ADA.

To the best of my knowledge, the above information is correct. I understand that it is my responsibility to inform this office of any changes in my medical status. I understand that, when deemed necessary for my safety and well-being, my prescription history may be viewed through the Virginia Prescription Monitoring Program. I authorize the dental staff to perform necessary dental services with my informed consent.

I authorize the release of any information relating to my dental insurance claims. I understand that I am ultimately responsible for all cost of dental treatment. I authorize payment directly to Tidewater Dental Arts of the group insurance benefit payable to me. Should this account become delinquent, I will pay all collection costs and legal fees incurred.

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Patient Name (Please Print) Parent or Guardian Name (Please Print)

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Signature of Patient, Parent or Guardian Date