TREE CITY FAMILY DENTAL
PATIENT REGISTRATION

PT ID _____ CHART ID _____

First Name: _____ Last Name: _____Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party Information: (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Email: _____

Home Phone: _____ _____Work Phone: _____ _____

Cell: _____ ☐ I would like to receive correspondence via text message.

Birth Date: _____Age: _____ Soc Sec: _____ Drivers Lic: _____

Sex: ◯ Male ◯ Female ◯ Marital Status: ◯ Married ◯ Partnered ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Email: _____ ☐ I would like to receive correspondence via email.

Section 2

Referred By: _____

Emergency Contact: _____

Relationship: _____ # _____

Physician Name: _____# _____

Specialists: _____# _____

Section 3

Employment: ◯ Full Time ◯ Part Time ◯ Self Employed ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Preferred Dentist: _____

Employer ID: _____ Preferred Pharmacy: _____

Carrier ID: _____ Preferred Hygienist: _____

Primary Insurance Information:

Name of Subscriber: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Dependent ◯ Other

Member ID/Subscriber ID/Social: _____ Insured Birth Date: _____

Employer: _____ **Insurance Company**: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Phone #: _____ Phone #: _____

Secondary Insurance Information:

Name of Subscriber: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Dependent ◯ Other

Member ID/Subscriber ID/Social: _____ Insured Birth Date: _____

Employer: _____ **Insurance Company**: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Phone #: _____ Phone #: _____

TREE CITY FAMILY DENTAL
MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions completely and to the best of your knowledge.

Are you currently under a physician's care? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken Phen-Fen or Redux? ◯ Yes ◯ No If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any
Other medications containing bisphosphonates? ◯ Yes ◯ No If yes, please explain: _____
Are you on a special diet? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been diagnosed with Sleep Apnea? ◯ Yes ◯ No If yes, please explain: _____
Do you use tobacco? ◯ Yes ◯ No If yes, please explain: _____
Do you use controlled substances? ◯ Yes ◯ No If yes, please explain: _____

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Other If other, please explain: _____

Do you have, or have you had any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Fainting /Dizziness ◯ Yes ◯ No	Intestinal Disease ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach Problems ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Heart Attach/Failure ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Disease ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Troubler ◯ Yes ◯ No	Pre-medication ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If Yes, please explain:

_____
_____
_____
_____
_____
_____

To The best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ DATE: _____

TREE CITY FAMILY DENTAL
DENTAL HISTORY

What is your immediate dental concern? _____

Previous Dentist: _____ How Long? _____

Most Recent Dental Exam: _____ Most Recent Dental Xrays: _____

How Often Do You Have Your Teeth Cleaned? ☐ 3 months ☐ 4 months ☐ 6 months ☐ 1 year or longer

Please check all that apply:

A. Sensitivity- ☐ Hot ☐ Cold ☐ Pressure ☐ Biting ☐ Sweets ☐ Root Surface ☐ Generalized ☐ Specific Teeth

Explain: _____

B. Previous **Orthodontic** Treatment (Braces) ☐ Yes ☐ No When? _____

C. Previous **Periodontal** (Gum) Treatment ☐ Yes ☐ No When? _____

D. Have you lost any permanent teeth? ☐ Yes ☐ No

-Have you had any difficulty with extractions? ☐ Yes ☐ No

-Have you ever had prolonged bleeding? ☐ Yes ☐ No

E. Do you have difficulty swallowing or gag easily? ☐ Yes ☐ No

F. Do you have dry mouth, throat or eyes? ☐ Yes ☐ No

G. **Temporomandibular Joints**- Do you experience:

☐ Clenching or Grinding of your teeth ☐ Discomfort when chewing in joints ☐ Popping or Clicking

☐ Frequent morning headaches ☐ Locking Jaw ☐ Difficulty opening widely ☐ Wear a bite splint or Night Guard

H. How would you rate your anxiety level during treatment? ☐ Low ☐ Medium ☐ High

-Unfavorable dental experiences? ☐ Yes ☐ No When? _____

-Dental Fears? ☐ Yes ☐ No When? _____

_Difficulty Getting/Staying Numb? ☐ Yes ☐ No When? _____

I. Appearance:

Are you pleased with the appearance of your teeth? ☐ Yes ☐ No

Are you interested in changing your smile? ☐ Yes ☐ No

Supplemental Dental History:

If you are wearing a partial or complete artificial denture, please complete the following:

1- When did you receive your first partial or complete denture? _____
2- How long have you worn your present denture? _____
3- Is your present denture a problem? ☐ Yes ☐ No Describe:_____
4- Has your present denture ever been relined? ☐ Yes ☐ No When? :_____
5- Are you satisfied with the appearance? ☐ Yes ☐ No Describe:_____
6- Are you satisfied with the comfort? ☐ Yes ☐ No Describe:_____
7- Are you satisfied with the chewing ability? ☐ Yes ☐ No Describe:_____

Patient's Signature: _____ Date: _____

Doctor's Remarks: _____

_____

_____

Doctor's Signature: _____ Date: _____

TREE CITY
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treecitydental.com

Payment Policy

For those patients with insurance coverage, we make every effort to file the appropriate code(s) documented in the patient's dental record. Our office is given service codes and guidelines to follow to prevent inappropriate charges being billed to your insurance. Our dentists diagnose based on what they feel is in the patient's best interest, and not necessarily what the insurance company allows. Knowledge of waiting period or non-coverage of certain treatment is the responsibility of the patient.

All charges, including the insurance portion, are the patient's responsibility. We ask that if your insurance has not paid within 45 days, that you follow up with them. Please direct your questions regarding your benefits and coverage to your insurance company prior to your appointment.

In accordance with the Federal Truth-In-Lending Act which requires all doctors to give their patient information in connection with extension of credit, please be advised of the following policies which apply in this office. The responsible party agrees to:

1. Pay the doctor at the time treatment or service is received or by previous arrangements.
2. That if payments are extended beyond 90 days from the date of first billing to pay 1.5% per month on the unpaid balance (annual rate of 18%) with a minimum charge of $1.00 per month.

I/We agree to pay cost and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.

Signature_____ Date_____

Cancellation Policy

At Tree City Family Dental, we make every effort to be on time for our patients, and ask that you extend the same courtesy to us. If you cannot keep an appointment, please give us at least 48 hours notice. This courtesy on your part will make it possible for us to give the appointment to another patient who needs to be seen. We understand that situations may arise that would make it impossible for you to give 48 hours notice and each incident will be given consideration based upon your appointment history. Missed or broken appointments without notice may be charged to the patients account. The broken appointment fee is $50.00.

Signature_____ Date_____

TREE CITY
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treecitydental.com

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ received a copy of Tree City Family Dental's Notice of Privacy Practices, read and understood the contents and refused to take home a copy.

_____(printed name)

_____(signature) _____(date)

I, _____ received a personal copy of the Notice of Privacy Practices of Tree City Family Dental.

_____(printed name)

_____(signature) _____(date)

Office use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (please specify) _____

Privacy and Communication:

You have a choice on how we communicate with you. For convenience, you may request that we communicate with you via unencrypted email or text messages, however we are required to inform you of the security risks. Unencrypted emails and text messages are not secure while being sent between our server and your inbox. There is a possibility that the messages can be intercepted and read by a third party and you would never know that it happened. Additionally these messages are often stored on unsecured devices such as shared computers and smartphones. Despite taking these precautions, it is also possible for messages to be sent to the wrong email or phone number, and once sent these messages are unable to be recalled. If you would still like us to communicate with you via email or text, please indicate on intake paperwork acceptance of communications through text or email. Otherwise, please indicate that you would like to communicate via secure methods such as phone, in person, or postal service.

TREE CITY FAMILY DENTAL
Notice of Privacy Practices

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

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Tree City Family Dental. "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Tree City Family Dental's Privacy Official at:

Duston F Connaughton DDS – TCFD HIPAA Compliance Officer
dc@treecitydental.com PH(208)286-2699 FAX(208)350-6525 7301 W. Emerald St. Ste. 102 Boise, ID 83704

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. **We are required by law to**:

- Maintain the privacy of your protected 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.

IV. Last Revision Date This Notice was last revised on July 25, 2019.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may 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.

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

3. 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.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. 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.

6. 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.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. 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.

2. 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 medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

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

4. 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.

5. 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.

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

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

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

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

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

11. Specialized Government Functions. We may disclose your 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.

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

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

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. 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 HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review 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.

B. Right to 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.

C. Right to 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.

D. Right to Confidential Communications, Alternative Means and 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.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) 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 HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may 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.

F. Right to 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.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our 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 is July 25, 2019.

X. How 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 the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

TREE CITY
FAMILY DENTAL
treecitydental.com

Authorization to Release Dental Records

Patient Name(s) _____

Date of Birth _____

Phone_____

Current Dentist

Name_____

Phone_____

Fax_____

Please email records to: office@treecitydental.com

Emailing records is preferred, but if mailing them please send to:

Tree City Family Dental

7301 W. Emerald St. Suite #102

Boise, ID 83704 **Phone# (208)286-2699**

I consent to the release of all dental records and notes including x-rays obtained through my entire course of all dental treatment and diagnosis from any dentist who has provided care for me.

Signature_____ **Date**_____