

 **Patient Registration**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Patient Information***

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

€M €F Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

€Married €Single €Divorced €Minor E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

***Who can we thank for your referral?:*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HAVE YOU TRAVELED LATELY? YES / NO WHERE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IN CASE OF AN EMERGENCY, WHO SHOULD WE CONTACT?**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other #: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Responsible Party (For Minors Only)***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

€M €F Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Insurance Information***

Insurance Co. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Owner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*THE X-RAYS OF THE PATIENT’S TEETH ARE PROPERTY OF THIS OFFICE BY LAW. AN ADDITIONAL CHARGE WILL BE REQUIRED FOR ANY COPY YOU MAY NEED.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Responsible Party Date

**Medical History**

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Visit: \_\_\_\_\_\_\_\_\_\_

Are you under the care of a physician? € Yes € No Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications or drugs? € Yes € No Please List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been hospitalized in the last 5 years? € Yes € No Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ARE YOU ALLERGIC TO OR HAVE HAD AN ADVERSE REACTION TO:**

€ Penicillin € Erythromycin € Codeine € Sulfa € Advil/Motrin € Iodine € Latex

€ Tetracycline € Local Anesthetics € Barbiturates € Aspirin € Other: \_\_\_\_\_\_\_\_\_\_\_ Yes / No

**Check if you have or ever had…**

€ Yes € No AIDS/HIV

€ Yes € No Anemia

€ Yes € No Arthritis/Rheumatism

€ Yes € No Artificial Heart Valves

€ Yes € No Artificial Joints

€ Yes € No Asthma

€ Yes € No Back Problems

€ Yes € No Excessive Bleeding

€ Yes € No Blood Disease

€ Yes € No Cancer

€ Yes € No Chemical Dependency

€ Yes € No Chemotherapy

€ Yes € No Circulatory Problems

€ Yes € No Congenital Heart Lesions

€ Yes € No Cortisone Treatments

€ Yes € No Diabetes

€ Yes € No Emphysema

€ Yes € No Epilepsy

€ Yes € No Fainting/Dizziness

€ Yes € No Glaucoma

€ Yes € No Headaches

€ Yes € No Heart Murmur

€ Yes € No Heart Problems

€ Yes € No Hepatitis

€ Yes € No Herpes

€ Yes € No High Blood Pressure

€ Yes € No Jaundice

€ Yes € No Jaw Pain

€ Yes € No Kidney Disease

€ Yes € No Liver Disease

€ Yes € No Low Blood Pressure

€ Yes € No Mitral Valve Prolapses

€ Yes € No Nervous Problem

€ Yes € No Pacemaker

€ Yes € No Psychiatric Care

€ Yes € No Radiation Treatment

€ Yes € No Respiratory Disease

€ Yes € No Rheumatic Fever

€ Yes € No Shortness of Breath

€ Yes € No Sinus Trouble

€ Yes € No Stroke

€ Yes € No Swollen Feet/Ankles

€ Yes € No Thyroid Problems

€ Yes € No Tonsillitis

€ Yes € No Tuberculosis

€ Yes € No Tumor on Head/Neck

€ Yes € No Ulcer

€ Yes € No Venereal Disease

Please list any other disease/condition you may have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women:** Are you pregnant? € Yes € No Are you nursing? € Yes € No Taking birth control pills? € Yes € No

 I am aware that when on antibiotics therapy, my birth control may not be effective. \_\_\_\_\_\_\_\_\_ Initials

**Dental History**

Purpose of Today’s Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Former Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you: Brush?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Floss?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had: € Orthodontics € Gum Treatment € Root Canal € Implants € Crowns

Are you happy with the appearance of your teeth? € Yes € No

**Check if you have or ever had…**

€ Yes € No Bad Breath

€ Yes € No Bleeding gums

€ Yes € No Blisters on lips/mouth

€ Yes € No Broken fillings

€ Yes € No Burning

€ Yes € No Clicking jaw

€ Yes € No Dry mouth

€ Yes € No Fingernail biting

€ Yes € No Grinding teeth

€ Yes € No Gums swollen

€ Yes € No Jaw pain/tiredness

€ Yes € No Lip/cheek biting

€ Yes € No Loose teeth

€ Yes € No Mouth breathing

€ Yes € No Pain around ear

€ Yes € No Sensitivity to cold

€ Yes € No Sensitivity to hot

€ Yes € No Sensitivity to sweets

€ Yes € No Smoking

***I CERTIFY THAT ALL THE INFORMATION STATED ON THIS FORM IS CORRECT. I ALSO UNDERSTAND THAT THE DENTIST IS NOT RESPONSIBLE FOR ANY ACTION TAKEN OR NOT TAKEN DUE TO ERRORS WHEN FILLING OUT THIS FORM.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Responsible Party Signature of Doctor Date

**CONSENT FORM**

PROPOSED TREATMENT

 **1. DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions including redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). **Initials \_\_\_\_\_\_\_\_\_**

 **2. CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because conditions were found while working on the teeth that were not discovered during examination, the most common being endodontic treatment. I also understand that any/all changes will be added to my treatment plan as necessary. **Initials \_\_\_\_\_\_\_\_\_**

 **3. LOCAL ANESTHESIA**

The administration of any anesthesia involves certain risks including but not limited to: nausea, vomiting, pain, swelling/inflammation, allergic and/or unexpected reactions. If severe allergic reaction occurs, this can lead to more serious respiratory (lung) or cardiovascular (heart) problems, which may require treatment. In addition, there may be other risks which may include infection in the area of injection, injury to nerves or blood vessels in the area, disorientation confusion, and/or or prolonged drowsiness. I understand the risks of administrating anesthesia. **Initials \_\_\_\_\_\_\_\_\_**

 **4. COMPOSITE RESTORATIONS (FILLINGS)**

Composite fillings (white filling) are used to restore teeth from decay. I understand that the teeth treated may remain sensitive or even possibly quite painful both during and after completion of treatment.  Regardless of which material is utilized I understand the risks which may occur even though care and diligence will be exercised in rendering this treatment. These risks include the possibility of unsuccessful results and/or failure which may need further treatment such as root canal therapy, extraction, etc. I also understand that restorations may break/fracture and/or change color. This can be due to many factors which the Dentist has no control over. **Initials \_\_\_\_\_\_\_\_\_**

 **5. PULP CAP #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Sometimes after getting all the decay out there is a spot where the nerve has been reached, which will normally bleed a little. This is called "an exposure". The text-book thing to do is a root canal, but if the exposure is small and the bleeding is slight, the dentist will opt to do a pulp cap. This is used when the nerve is irritated but still alive and healthy enough to repair itself given a reasonable chance. The pulp-cap gives it a chance by getting rid of the decay and the bacteria and by creating a clean dressing over it with the filling. I understand that a pulp cap is a preventive method used to try to avoid endodontic therapy but is not guaranteed. **Initials \_\_\_\_\_\_\_\_\_**

 **6. ENDODONTIC TREATMENT (ROOT CANAL) #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I realize that there is no guarantee that endodontic therapy will save my tooth. I understand that there are risks and complications involved during root canal treatment. Some of the risks and complication of treatment are, but not limited to, pain, swelling, breakage of instrument inside canal, extension of instrument through the root, etc. I understand that additional surgical procedures may be necessary following the root canal treatment. **Initials \_\_\_\_\_\_\_\_\_**

 **7. EXTRACTIONS #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.). I authorize the treating Dentist to remove the following teeth for the necessary for reasons. I understand removing teeth does not always remove all the infection, if any, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, bruising, spread of infection, dry socket, jaw fracture, and/or numbness of the lips, tongue, and floor of the mouth, cheeks and/or surrounding tissue that can last for an indefinite period of time. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment. **Initials \_\_\_\_\_\_\_\_\_**

***I understand that dentistry is not an exact science and therefore practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I agree to follow any preoperative and postoperative instructions given to me. I understand that it is my responsibility to contact the Dentist and seek attention should any circumstances occur postoperatively. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction and consent to the proposed treatment.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient/Responsible Party

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Responsible Party Date



**OUR OFFICE POLICIES**

**X-RAYS AND EXAMINATION**

**I authorize *Dr. Novara Dr. Rico* to perform dental examination, take all x-rays, and all photographs required to properly diagnose my dental health and provide an effective treatment plan. \_\_\_\_\_\_\_** Initials

**I authorize Doral Family Dental to share my x-rays, pictures, and/or models with others for teaching and/or marketing purposes. All identifying information will be removed. \_\_\_\_\_\_\_** Initials

**I authorize Doral Family Dental to send me emails/text messages regarding my appointments or promotions. In case of any emergency please call 911 or proceed to the nearest emergency room,**

**DO NOT USE THIS WAY OF COMMUNICATION FOR THAT PURPOSE. X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature.**

**APPOINTMENTS**

Please be aware that we reserve the right to charge *$50.00* to your account for appointments cancelled or broken without a minimum notice of 24 hours. Also deposits made to hold appointments are

non- refundable. **\_\_\_\_\_\_\_** Initials

**INSURANCE**

As a courtesy to our patients, we are providers for some dental insurance companies. Most policies do not cover 100% of the cost of your treatment. We will estimate your coverage as closely as possible, based on information we receive from your insurance company, but until we actually receive payment from them, it is just an estimate. I acknowledge responsibility for payment of services rendered on my behalf. I also authorize the office of *Dr. Novara / Dr. Rico* to file all claims pertaining to my treatment. I authorize my signature to be on file for all insurance claims. **If my insurance plan does not cover completely the cost of my care within 45 days, I acknowledge full responsibility for payments pertaining to my treatment. \_\_\_\_\_\_\_** Initials

**PAYMENTS**

Payment is due at the time services are rendered. **Patients are expected to pay in CASH, VISA, MASTERCARD, AMERICAN EXPRESS OR DISCOVER. Sorry, we do not accept personal checks.** We also have various companies that offer payment plans (Citicard, Carecredit and Chase). These plans only take a few minutes to apply and allow you to start treatment today and spread payment over time.

**Should it be necessary to collect my account through an attorney or collections agency, I hereby agree to pay all costs of collections, all attorney fees, court costs, and any other costs related to the collection of my account.**

*I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Responsible Party Date



As required by the privacy regulations created as a result of the health insurance portability and accountability act (HIPAA):

We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our office concerning you IIHI. By the federal and state law, we must follow the items of notice of the privacy practices that we have in effect at the time. If you have any questions, regarding this notice of your health information privacy policies, please contact our private officer.

***BY SIGNING THIS DOCUMENT, I CERTIFY THAT A COPY OF THE NOTICE OF PRIVACY PRACTICES HAS BEEN PROVIDED TO ME AND THAT I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Responsible Party Date

**HIPAA - PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES**

 **\*HIPAA - CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE**

 **SALUD Y CONFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD**

**I acknowledge** that **I** have been provided with **DORAL FAMILY DENTAL**.**,** "Notice of Privacy Practices”, and I am giving my consent for the use and disclosure of Protect Health Information as required and**/**or permitted by law**.**

*\*Confirmo que* se *me ha proveído con la "Nota De Practicas* De *Privacidad" de* **DORAL FAMILY** DENTAL.**,** y *doy mi consentimiento para usar y compartir Información Personal De Salud como lo permita y/o requiera la ley.*

Patient **Name:** (please *prin****t)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

\**Nombre Del Paciente***: (***nombre* en letra de *molde por favor***)**

**Patient Signature *(****or legal representative; proof may* be *requested)­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\*Firma Del Paciente:* (o *representante legal; prueba* puedeser *requerida****)***

**Date:­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***\*Fecha:***

***­­*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM**

 **\*CONSENTIMIENTO DE CORREO ELECTRÓNICO/MENSAJES DE TEXTO A MÓVIL**

**Purpose:** This **form** is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information**. DORAL FAMILY** DENTAL., (DFD**)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number **of** risks **that** patients should consider before granting consent **to** use email/**mobile** text messaging for these purposes. **DFD** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **DFD** cannot guarantee the security and confidentiality **of** email/mobile text messaging communication and will not be liable for inadvertent disclosure of **confidential** information.

I acknowledge **that I** have read and **fully** understand **this** consent form. I understand the risks associated with communication **of** email/mobile **text** messaging between **DFD and I**, and consent to **the** conditions **outlined herein**. Any questions I may have **had** were answered.

**\*Propósito**: Esta forma es usada como consentimiento de usted para comunicarnos vía correo electrónico/mensaje de texto a móvil en referencia a su Información de Salud Protegida. **DORAL FAMILY DENTAL., (DFD**) ofrece a sus pacientes la oportunidad de comunicación vía correo electrónico/mensaje de texto a móvil. Trasmitir información vía correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. DFD usara formas razonables de proteger confidencial y seguro la información mandada a usted vía correo electrónico/mensaje de texto a móvil. De todas formas, DFD no podrá garantizarle proteger confidencial y seguro la comunicación vía correo electrónico/mensaje de texto a móvil y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

**Yo** comprendo haber leído y completamente entendido el consentimiento **de** esta forma. Yo comprendo los riesgos asociados con la comunicación **vía** correo electrónico**/**mensaje de texto a móvil entre **DFD** y yo, y consiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me ha sido respondida.

**Patient Acknowledgment** & **Agreement / \*Reconocimiento** y **Acuerdo del Paciente**

My **Consented Email Address** is: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Mi Correo Electrónico Consentido Es:*

My Consented Mobile Numberfor Text Messaging **is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Mi Numero* Móvil *Para Mensaje* De *Texto Consentido Es:*

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\****Firma* ***del*** *Paciente* ***\****Fecha

IN CASE OF EMERGENCY**:** Please call **911** or proceed to the nearest *emergency* room**. *Do*** not use this **way** of **communication for that** purpose. ***\*****EN* CASO *DE* EMERGENCIA**:** *Por favor llame* al **911** *o* proceda al centro de emergencia mas cercano. No use esta forma de comunicación para este *propósito.* Rev.09/19