TIMOTHY G. WILSON, D.D.S., P.C.

Premedication for dental appointments: Y or N

Joint replacements? Y or N

Heart Valves Y or N

Preferred method of contact: **Home Cell Work Text Email**

HIPAA:

_____ My initials indicate that I have been informed of my rights to privacy regarding my personal health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the full Notice of Privacy Practices is posted in the office and is available to me upon my request.

I give my permission for my dental health and treatment to be shared with:
Spouse, parent or guardian: Y or N **Dental professional:** Y or N
Other: _____ **Relationship**: _____
SIGNATURE OF PATIENT/RESPONSIBLE PARTY: _____
DATE: _____

Consent to treatment:

I _____ hereby authorize Timothy G Wilson DDS and /or staff to perform treatment mutually agreed upon by me. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks and I can ask for a complete recital of any possible complications
SIGNATURE OF PATIENT/GUARDIAN: _____DATE: _____

**I acknowledge being held responsible for understanding my dental coverage and that a pre-treatment estimate is not a guarantee of payment.
Initial: _____ Date: _____

I authorize the release of any information and/or records rendered to me, to other healthcare professionals, and/or insurance companies when necessary to aid in my diagnosis and/or treatment. I hereby authorize my dental insurance carrier to pay directly to my dental provider for services. I do not hold Tim G Wilson DDS and/or staff responsible to understand my insurance coverage in its entirety or responsible for lack of payment from insurance carrier on any treatment performed. I understand that if the insurance claim has been 60 days without full payment that I am responsible for the remaining due balance immediately. I agree to be responsible for payment of all services rendered on my behalf, or my dependents, regardless of insurance coverage.

Initial: _____ Date: _____