Practice Questions, Consents, and Policies

Jason Tanguay, DDS * Lindsey Hollern, DDS

mint. *
dental studio

Tell Us About You!

* What qualities do you look for in a dentist and dental team?

* What was the reason you left your last dentist?

Help Us Make You Smile:

* Are you happy with the color of your teeth? yes ☐ no ☐
* Do you wish your teeth were straighter? yes ☐ no ☐
* Is there anything you would like to change about your smile?

Consent for Exam:

Consent for exam, any appropriate hygiene services and life saving procedures

I, the undersigned patient, hereby authorize the Jason Tanguay, DDS, LLC to perform the procedure(s) or course(s) of treatment listed below including but not limited to comprehensive evaluation of my oral condition, diagnostic tests, radiographs, diagnostic casts, cleaning of my gums and teeth and fluoride application if needed. I understand that the risks associated with cleaning of my gums and teeth include: tenderness of gums lasting several days after the cleaning, transient sensitivity of my teeth to temperature and soreness of my jaw from holding my mouth open.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize the provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I understand that a blood transfusion may be a part of a life-saving procedure and give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure.

I understand I may be offered to have my jewelry (rings, etc.) cleaned with an ultrasonic jewelry cleaning device during my appointment. I understand Jason Tanguay, DDS, LLC is not responsible for any damage to my jewelry, including loose or lost stones.

Financial Policy:

I understand that payment for care is due the day it is received and that Mint* Dental Studio will submit if appropriate dental benefit paperwork on my behalf. Unless prearranged with Mint* Dental Studio, unpaid balances will be assessed a 10% monthly fee. Balances not paid before the specified due date will be assessed a $25.00 late fee. There is a $25.00 fee for all NSF checks. I further understand that if my account is delinquent over 180 days, then I am responsible for any collection agency costs, court costs and legal fees.

I may be given a treatment plan with the recommended treatment options and associated fees. The estimated fees are valid for 120 days from the date of the estimate and any treatment which progresses after 120 days may be subject to increased fees.

HIPPA Policy:

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: 1.Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment) 2. Obtaining payment from third party payers (e.g. my insurance company) 3.The day-to-day health care 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 that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Cancellation Policy:

Please help us deliver outstanding and timely dental care to you and busy patients like you! We know and appreciate that you want to achieve and maintain health, but sometimes lead a hectic life. We are happy to seek to find a convenient appointment time for you or to reschedule any appointment if needed. If you find that you need to change an appointment time, please provide us with TWO BUSINESS DAYS NOTICE. This ensures that other busy patients like you can be seen in a timely manner and helps keep costs down so that we may offer you affordable dental care.

Please know we may elect to charge a $100.00 cancellation fee for cancellations made with less than two business days' notice.

Minor/Child Consent:

I, being the parent or guardian of said child do hereby agree to the above consents and policies on behalf of my child whether or not I am present at the actual appointment when the treatment is rendered.

Acknowledgment:

* Relationship of person completing this form to patient _____

* Name of person signing this form (If not the patient) _____

I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue.

Signature

Date