TRIANGLE Kids
PEDIATRIC DENTISTRY
Bright Smiles Since 1975

3115 Academy Rd, Suite B | Durham, NC 27707
424 N Madison Blvd | Roxboro, NC 27573
Phone: (919) 493-2569 | Fax: (919) 493-5437
care@trianglekidsdentist.com
Trianglekidsdentist.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA ACKNOWLEDGMENT)

I _____ (printed name), acknowledge I have been provided a reference copy of the HIPAA Notice of Privacy Policy (copy found at trianglekids.info or in office) and may request a copy of said policy.

Furthermore, I understand my personal health, insurance or other personal information collected by Triangle Kids Pediatric Dentistry will only be used as described in the aforementioned Notice of Privacy policy.

My signature at the bottom of this page indicates I have received, read, and understand that Triangle Kids Pediatric Dentistry has communicated, to me, my rights under HIPAA.

Legal Guardian's Signature _____

Date_____

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Authorization and Consent

To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Triangle Kids Pediatric Dentistry to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Triangle Kids Pediatric Dentistry health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Triangle Kids Pediatric Dentistry may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- **Triangle Kids Pediatric Dentistry does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.**

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Triangle Kids Pediatric Dentistry already sent before receiving my written instructions to stop.

Patient name (please print) _____

Signature: _____ Date: _____

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Social Media Consent

At Triangle Kids Pediatric Dentistry we would love to highlight and capture great achievements of our patients. For example, your child's first appointment, having a zero plaque score, stopping a thumb habit, or cute Halloween costumes.

Please fill out this form to let us know your preferences.

May we take photos and videos of your child(ren) in the clinic for use on social media (full names will never be used)?

☐ I consent that Triangle Kids-Pediatric Dentistry may use photographs/videos of my children or myself on the practice's social media pages, website, emails or other marketing materials.

☐ I do not consent to use of photos/videos of my children for any marketing means.

Please list name of children here:

_____

_____

_____

_____

_____

Parent/Guardian Name (Please Print):_____

Signature: _____ Date:_____

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Insurance Information

If you have dental insurance and would like help in completing a standard American Dental Association claim form to submit for reimbursement from your insurance company, complete the information listed below.

Policy Holder Name_____
First Last Middle Initial Date of Birth

Home Address _____
Street City State Zip

Policy Holder SSN and/or Member ID #_____

Relationship to Patient_____

Employer Name _____

Insurance Company Name _____

Group # (if applicable) _____

Phone Number of Insurance Company _____

Address to Mail Dental Claims To:

_____
Street/P.O. Box

_____
City State Zip Code

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient(s) Name: _____ Date of Birth: _____

I request and authorize _____
Name & Phone Number of Previous Dentist

to release healthcare information of the patient named above to:

PLEASE FAX/MAIL/EMAIL TO:
Triangle Kids – Pediatric Dentistry
3115 Academy Road, Suite B
Durham NC 27707
P: 919-493-2569 F: 919-493-5437
care@trianglekidsdentist.com

This request and authorization applies to:

☐ All Dental Records

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

Legal Guardian's Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.