elevate dental

Welcome

In scheduling your first appointment, you have taken the first step to achieving the smile you've always envisioned!

We are dedicated to caring for you as if you were a member of our family. We provide comprehensive care and believe that oral health affects the entire body and overall wellness.

We strive to be proactive, preventing disease rather than reacting. We are committed to continuing to educate ourselves and seeking the latest technologies to improve your patient experience.

Together, we will explore and examine your teeth and create your personalized treatment plan. Our goal is to help you achieve a smile that's as healthy and functional as it is resilient and beautiful. We will guide and coach you to reach that goal!

We have set aside 2 hours just for you, please plan accordingly. We hope to receive all your information/paperwork a week ahead of time so we can properly prepare for your arrival.

Thank you! Look forwarding to meeting you!

The Elevate Dental Team

TIME 03:00 PM DATE 1/18/2023

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

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

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

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

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Contact Person

credit card number

exp date

date last updated

security code

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

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

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

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

Rem. Benefits: Rem. Deduct:

MEDICAL HISTORY

Patient Name: _____ Birth Date: _____ Date: _____

Primary Care Physicians Name: _____ Phone #: _____

Have you been hospitalized or had major operation? Yes ◯ No ◯ If yes_____

Have you ever had a serious head or neck injury? Yes ◯ No ◯ If yes_____

Are you taking any medications? Please list with dosages (including vitamins, herbs etc.)

_____

_____

_____

Do you take, or have you taken Phen-Fen or Redux? Yes ◯ No ◯

Have you ever taken Bisphosphonates* Yes ◯ No ◯ *Examples: Fosamax, Boniva, Actonel

Are you on a special diet? Yes ◯ No ◯

Do you use tobacco? Or have a history or smoking? Yes ◯ No ◯

Are you advised to take Pre-med by physician? Yes ◯ No ◯ If yes, what do you take? _____

Women: Are you…… Pregnant ◯ Nursing ◯ Taking oral contraceptives ◯

ALLERGIES: Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯

Metal ◯ Latex ◯ Sulfa Drugs ◯ Local Anesthetics ◯

Allergies not listed above: _____

Do you use controlled substances or recreational drugs? Yes ◯ No ◯ If yes, _____

Do you have, or have you had, any of the following? Check off either Y (yes) or N (no) below.

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV Positive			Cortisone medicine			Hemophilia			Radiation treatment		
Alzheimer's			Diabetes			Hepatitis A			Recent weight loss		
Anaphylaxis			Drug Addition			Hepatitis B or C			Renal dialysis		
Angina			Easily Winded			Herpes (lip or mouth)			Rheumatic fever		
Arthritis/gout			Emphysema			High Blood pressure			Scarlet fever		
Artificial heart valve			Epilepsy or seizures			High Cholesterol			Shingles		
Artificial joint			Excessive Bleeding			Hives or Rash			Sickle cell disease		
Asthma			Excessive Thirst			Hypoglycemia			Sinus trouble		
Blood disease			Fainting spells/dizzy			Irregular heartbeat			Spina bifida		
Blood transfusion			Frequent Cough			Kidney problems			Stomach/intestinal disease		
Breathing Problems			Frequent Diarrhea			Leukemia			Stroke		
Bruise Easily			Frequent Headaches			Liver disease			Swelling of limbs		
Cancer			Genital Herpes			Low blood pressure			Thyroid disease		
Chemotherapy			Glaucoma			Lung disease			Tonsillitis		
Chest Pains			Hay Fever			Mitral valve prolapse			Tuberculosis		
Cold Sores			Heart attack/failure			Osteoporosis			Tumors or growths		
Congenital heart disorder			Heart Murmur			Pain in jaw joint			Ulcers		
Convulsions			Heart pacemaker			Parathyroid disease			Veneral disease		
Yellow Jaundice			Sleep Apnea			Psychiatric care			Blood thinner		
Human Papilloma Virus (HPV)			ADD/ADHD			Use of C-PAP			Autism/Asperger syndrome		
Multiple Sclerosis											

DENTAL UPDATE QUESTIONNAIRE

Name _____ Date:_____
Are you experiencing any discomfort? _____ If yes explain_____
Does dental treatment make you nervous? _____
Date of last dental visit _____ Date of last dental cleaning _____
Have you ever been treated for gum disease?_____
How often do you brush? _____ Type of tooth brush: manual ◯ electric ◯ Do you floss? _____
Do you wear a mouthguard made by a dentist at night? _____

Please check off if you have or ever had any of the following:

MOUTH
◯ Bleeding sore gums
◯ Unpleasant taste/bad breath
◯ Burning tongue/lips
◯ Frequent blisters
◯ Swelling/lumps
◯ Clicking or popping jaw
◯ Difficulty opening/closing
◯ Braces or Invisalign

TEETH
◯ Loose teeth
◯ Sensitivity to hot
◯ Sensitivity to cold
◯ Sensitivity to sweets
◯ Sensitivity to biting
◯ Food catching between teeth
◯ clenching or grinding, if so when…. ◯ daytime ◯ nighttime
◯ shifting in bite

Is there anything you would like to change about your smile? _____
What things are most important to you about your dental health? _____
Have you lost any teeth? _____ if so, have they been replaced? _____ if not, why? _____
Are you unhappy with the replacements? _____ if so why? _____
Would you be interested in learning more about replacements? _____
Do you have any difficulty getting numb? _____ if yes explain _____
Have you experienced any problems or complications with previous dental treatment? If yes, please explain.
_____

Please circle your answer to the following 7 statements:

1.) My mouth is a.) very comfortable b.) moderately comfortable c.) uncomfortable

2a) I think the appearance of my mouth is excellent
2b) I am satisfied with the appearance of my mouth
2c) I am disappointed with the appearance of my mouth

3a) I have set goals for my oral health with a previous dentist
3b) I want to set goals concerning my dental health

4a) I have put dentistry for myself and family high on priority list completed
4b) I have put dentistry for myself and my family low on priority list
4c) I have dentistry on my list, but its hard to find

5a) I will do anything to keep my natural teeth
5b) I want to keep my teeth, but have a budget of time and money I am willing to spend
5c) I expect I will lose most/all of my teeth like my parents did

6a) I have always done the best recommended for my dental health
6b) I have not done what dentists have recommended to me
6c) I rarely go and don't care about having any dental work

7.) I think my present state of dental health is a.) excellent b.) good c.) poor
What are some questions about dentistry that you have never had adequately answered? _____
_____

Med. Hx Continued….

Have you ever had any serious illness not listed above? Yes ◯ No ◯ If yes _____

Have you been told you needed to have a sleep study? Yes ◯ No ◯ If yes _____

If yes to cancer, what type of cancer, when? _____

_____

_____

If yes to chemo/radiation, if so when? How many Grays (Gy) have you been exposed to?

_____

_____

Comments:

_____

_____

_____

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

Signature of Patient, Parent or Guardian

X _____ Date _____

Financial and Appointment Policy

Financial & Appointment Policy

Payment for all patient balances is due immediately after treatment is completed. Please ask us in advance if you are interested in learning about third party financing.

Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. As a courtesy, Elevate Dental submits insurance claims for payment on the patient's behalf. I understand that I am ultimately responsible for any portion of treatment not covered or paid by my insurance provider. If dental insurance is listed on my account, I acknowledge that the clinic has estimated my patient balance based on the insurance information I have provided. However, final payment responsibility is determined by my insurance provider's terms and coverage in effect on the date of service. Therefore, any patient payment made prior to insurance processing is not considered final until the insurance payment is received.

I authorize the use of my signature on all insurance submissions. Elevate Dental may use my healthcare information and may disclose such information to the above insurance company or companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

If you utilize Delta Dental as your dental benefits provider, they will not assign benefits to us (pay us). Therefore, payments for all treatment will be due in full at time of service and Delta will pay your benefits by a mailed check to your address. Please make sure your mailing address is up to date with us and delta dental. If you have a secondary insurance, it is your responsibility to email us the "Explanation of Benefits" (EOB) from Delta Dental which should come with your check and we will submit your secondary claim. If we do not receive your EOB, we will be unable to submit your secondary claim.

Estimates and treatment plans are based upon information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. This is a preliminary estimate only and lab charges (if applicable) have been estimated and included total.

Estimates do not take into consideration any money that was billed toward my financial maximum or treatment limits that may have been used at other dental clinics.

Predeterminations are submitted by patient request and are NOT a guarantee of payment.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The clinic will make an effort to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

By signing below, I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and/or my family including a minor/child.

Commitment to Appointments:
Please be present for your scheduled appointments. In this way, we can best serve your dental needs. We ask that on the rare occasion you need to cancel or change an appointment you give us a 48 hour notice or 2 business days. If your appointment is broken or cancelled without a 48 hour notice, a fee of $84 for cleaning appointments and/or $132 for doctor appointments will be applied to your account. By signing below, I understand our commitment to appointment policy.

First Name
-

Last Name
-

Patient or Legal Guardian Signature (ESign)

Date :

General Dental Consent Form

I authorize dental treatment including necessary or advisable examination, radiographs (x-rays), diagnostic aids or local anesthesia. In general terms, dental treatment may include but is not limited to one or a number of the following:

- Administration of local anesthesia
- Cleaning of the teeth and application of topical fluoride
- Scaling and root planing with local anesthesia
- Application of sealants to the grooves of the teeth
- Treatment of diseased or injured teeth with dental restorations
- The replacement of missing teeth with a dental prosthesis (crown, partials, etc.)
- Treatment of diseased or injured oral tissues (hard and/or soft)
- Treatment of malposed (crooked) teeth and/or developmental abnormalities.
- Treatment of the canal or pulp chamber that lies in the middle of the tooth and its root also known as "endodontic" therapy or root canal

Risk of Dental Procedures in General:

While unlikely, these are potential risks involved from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections: pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth. Thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms. Tempromandibular joint (TMJ) difficulty, loosening of teeth or restoration in teeth, injury to other tissues. Referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness, lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give my permission to the dentist to make any/all changes and additions as necessary. Alternative Treatment I understand that I have the right to choose, on the basis of adequate information, from alternate treatment plans that meet professional standards of care. By signing below, I consent to the general treatments and/or proposed treatment

First Name
-

Last Name
-

E-Signature (draw, upload or type) (ESign)

Date :

Date
-

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ELEVATE 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 ELEVATE DENTAL ("Dental Practice"). "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 ELEVATE DENTAL'S Privacy Official at:

369 HEINEBERG DRIVE, COLCHESTER, VT 05446

802-658-4873

802-863-5400

INFO@ELEVATEDENTALVT.COM

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 February 15, 2022.

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

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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.

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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

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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

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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 2/15/2022.

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.

Notice of Privacy Practices

Consent for Use and Disclosure of Health Information

Patient Information

First Name _____ **MI** _____**Last Name** _____

Address _____**Phone Number** _____

Email _____

Signing below, I have thoroughly read Elevate Dental's Notice of Privacy Practices and understand how my medical information may be used and disclosed and also how I am able to get access to my medical information.

Patient Signature: _____Date _____

Please initial each statement below:

_____ **I understand and acknowledge my rights as detailed in the Notice of Privacy Practices Presented here.**

_____ **I understand and consent to my medical information being used as described here.**

_____ **I understand the terms and authorize the practice to disclose my medical information to those parties as mentioned here.**

Kristen Gibilisco DMD FAGD FICOI & Michael Gibilisco DMD
369 Heineberg Dr., Colchester, VT 05446
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elevate dental

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RECORDS RELEASE FORM

I, (print full legal name), _____, on (date)_____, give permission to the office of (indicate below) to release my records:

Please indicate your transfer status below:

_____ I am becoming a NEW patient at Elevate Dental -- please provide PREVIOUS office information below, so we may obtain your PREVIOUS records

_____ I am transferring from Elevate Dental to another office -- please provide your forwarding office information below, so we may send your records as requested

_____ I will be continuing care with Elevate Dental, but will be seeing an additional provider

Office Information:

Address: _____

Phone/Email: _____

Comments / Reason for Transfer: _____

Additional dependents (children under 18) to release records to the same office as noted above:

_____

_____

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____