NORTH SHORE
Smile Surgery
Dental Implants | Periodontics | Oral Surgery

MEDICAL HISTORY and PRIVACY PRACTICES

I give permission for Dr. Scott Frank and/or Dr. Lindsay Powers and/or staff to discuss my medical treatment with:

Name: _____ Relationship: _____

Privacy Policy:

I acknowledge having received the Practice's "Notice of Privacy Practices." My rights, including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Practice has already made disclosure with my prior consent. **[X____]**

Information:

I have received information on the education, training, and competency of the doctor. **[X____]**

I certify that I have read and I understand the questions outlined on the patient medical history form. I acknowledge that my questions, if any, about the inquiries set forth on my Medical History Form have been answered to my satisfaction. I will not hold my surgeon, or any other member on his staff, responsible for any error or omission that I have made in the completion of this form.

Signature: X_____ Date: X_____

(Parent or Guardian if Minor)

Please print name: X_____ Dr. Review: [X___] Date: X_____