PATIENT NAME: _____ GENDER: M | F DATE OF BIRTH: _____
(please print patient's full name)

Name of person completing this form and their relationship to the patient named above: _____

Although dental personnel primarily treat teeth and mouths, your mouth is a part of your entire body. Health problems and medications often have an important interrelationship with the dentistry you will receive. Please answer the following questions for your child.

MEDICATIONS

Please list all ***medications, inhalers, and rescue medications*** your child is currently taking/using including dose and times per day:

_____

_____

_____

****If your child does have rescue medication and/or an inhaler, please *ALWAYS* bring them to dental visits****

MEDICAL HISTORY

Currently under a cardiologist's care?	Y N	Had a major operation or surgery?	Y N
Had a serious head or neck injury?	Y N	Frequently exposed to tobacco smoke?	Y N
On a special diet?	Y N	Vape or use tobacco?	Y N

If yes to any of the above questions, please explain: _____

Does your child have, or have they had, any of the below conditions? Please (circle) yes or no for each.

Congenital heart disease (CHD)	Y N	Unrepaired, cyanotic CHD	Y N
Artificial (prosthetic) heart valve	Y N	Repaired CHD (completely) in last 6 months	Y N
Previous infective endocarditis	Y N	Repaired CHD with residual defects	Y N
Damaged valve in transplanted heart	Y N	Been told by a doctor they need an antibiotic for dental?	Y N

*****Except for the conditions listed above, an antibiotic before prophylaxis and treatment is no longer recommended for any other form of CHD*****

Please (*circle*) yes or no for each item listed below.

AIDS, HIV, or HPV Positive	Y N	Down Syndrome	Y N	Liver Problems / Failure	Y N
Alopecia	Y N	Drug Addiction at birth	Y N	Mitral Valve Disease	Y N
Anemia	Y N	Eczema	Y N	MRSA	Y N
Alpha Gal	Y N	Ehlers Danlos Syndrome	Y N	Muscular Dystrophy	Y N
Anxiety	Y N	Epilepsy	Y N	PANDAS	Y N
Artificial Joint	Y N	Fainting Spells	Y N	Pendred Syndrome	Y N
Asthma	Y N	Febrile Seizures	Y N	Pregnant	Y N
Attention Deficit Hyperactivity Disorder (ADHD)	Y N	Feeding Tube (G-Tube)	Y N	Postural Orthostatic Tachycardia Syndrome (POTS)	Y N
Autism	Y N	Fetal Alcohol Syndrome	Y N	Radiation Treatments	Y N
Autoimmune Disease	Y N	Heart Attack / Failure	Y N	Reactive Airway Disease	Y N
Blind / Significant Loss of Eyesight	Y N	Heart Disease	Y N	Renal Dialysis	Y N
Blood Disease	Y N	Heart Murmur	Y N	Seizures (non-epileptic or febrile)	Y N
Blood Transfusion	Y N	Heart Pacemaker	Y N	Sensory Processing Challenges	Y N
Brain/Skull Injury	Y N	Hemophilia	Y N	Sexually Transmitted Disease	Y N
Bruises Easily	Y N	Hepatitis A, B, or C (circle)	Y N	Sickle Cell Disease/Trait	Y N
Cancer (Type:_____)	Y N	Herpes/Cold Sores/Fever Blisters	Y N	Speech Delays	Y N
Cerebral Palsy	Y N	High Blood Pressure	Y N	Spina Bifida	Y N
Chemotherapy	Y N	Hydrocephaly or Shunt	Y N	Stomach/Intestinal Disease	Y N
Cleft Palate / Lip	Y N	Hypoglycemia	Y N	Stroke	Y N
Cystic Fibrosis	Y N	Irregular Heartbeat	Y N	Thyroid Disease	Y N
Deaf / Hearing Loss	Y N	Juvenile Idiopathic Arthritis	Y N	Tonsillectomy / Adenoidectomy	Y N
Depression	Y N	Kidney Problems / Failure	Y N	Tourette Syndrome	Y N
Developmental Disorders/Delays	Y N	Learning/Intellectual Delays	Y N	Tumors	Y N
Diabetes (Type I or Type II)	Y N	Other: _____	Y N

**** TURN OVER ****

Does your child have any of the following diseases or problems?

Active Tuberculosis	Y N	Cough that produces blood	Y N
Persistent cough greater than a 3-week duration	Y N	Been exposed to anyone with tuberculosis	Y N

If you answered yes to any of the 4 items above, please return this form to the front desk immediately.

ALLERGIES

Is your child allergic to any of the following? Please (circle) yes or no for each.

Amoxicillin/Penicillin	Y N	Dairy	Y N	Peanuts	Y N
Antibiotics (Other): _____	Y N	Food: _____	Y N	Seasonal Allergies	Y N
Artificial Dyes	Y N	Local Anesthetics	Y N	Sulfa Drugs	Y N
Aspirin	Y N	Nickel	Y N	Tree Nuts	Y N
Codeine or Other Narcotics	Y N	Other: _____			Y N

Has your child ever had an anaphylactic reaction or been hospitalized for any of the above allergies or others? If YES, list below:

_____

OTHER INFORMATION

What is the most important thing to you about your child's future smile and dental health? _____

Does your child use fluoride toothpaste? Y N | **Do you help your child brush their teeth?** Y N | **Does your child floss?** Y N

Circle any of the following therapies your child is currently in: Food | Physical | Occupational | Speech | Other:_____

Circle any of the following habits your child has:

Cheek Chewing | Clenching | Grinding | Finger / Thumb Sucking | Mouth Breathing | Nail Biting | Pacifier | Snoring

Does your child have any of the following? Circle any that apply:

Acid Reflux | Bad Breath | Broken Tooth/Filling | Bleeding Gums | Chipped Tooth | Jaw Pain | Tooth Pain/Sensitivity | Sleep Trouble / Apnea

Circle any of the following your child frequently drinks: Chocolate Milk | Coffee | Energy Drinks | Milk | Juice | Soda | Sports Drinks | Tea | Water

How many times a day does your child snack? _____ What are they snacking on most often? _____

QUESTIONS FOR PATIENTS * 4 years old and Under *

Do you currently breastfeed?	Y N	Does your child use a pacifier?	Y N
How long did you breastfeed? _____		Does your child drink water yet?	Y N
Does your child drink milk at bedtime or through the night?	Y N	Does your child currently drink from a bottle?	Y N
If yes to the above question, are you brushing after?	Y N	Are you flossing your child's teeth?	Y N

FOR NEW PATIENTS:

Name of previous dentist: _____ Date of last visit: _____ Date of last cleaning: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my child's) health. I understand that it is my responsibility to inform the dental office of any changes to medical status.

_____ _____

Signature of Parent or Legal Guardian **Date**

Crabtree PEDIATRIC DENTISTRY

Welcome to our office!

Please tell us about your child/children:

1. Child's first name: _____ Middle initial: _____

Last name: _____ Preferred name: _____

Date of birth: _____/_____/_____ Age: _____ Gender: M / F

Favorite movie: _____

2. Child's first name: _____ Middle initial: _____

Last name: _____ Preferred name: _____

Date of birth: _____/_____/_____ Age: _____ Gender: M / F

Favorite movie: _____

3. Child's first name: _____ Middle initial: _____

Last name: _____ Preferred name: _____

Date of birth: _____/_____/_____ Age: _____ Gender: M / F

Favorite movie: _____

4. Child's first name: _____ Middle initial: _____

Last name: _____ Preferred name: _____

Date of birth: _____/_____/_____ Age: _____ Gender: M / F

Favorite movie: _____

5. Child's first name: _____ Middle initial: _____

Last name: _____ Preferred name: _____

Date of birth: _____/_____/_____ Age: _____ Gender: M / F

Favorite movie: _____

6. Child's first name: _____ Middle initial: _____

Last name: _____ Preferred name: _____

Date of birth: _____/_____/_____ Age: _____ Gender: M / F

Favorite movie: _____

7. Child's first name: _____ Middle initial: _____

Last name: _____ Preferred name: _____

Date of birth: _____/_____/_____ Age: _____ Gender: M / F

Favorite movie: _____

8. Child's first name: _____ Middle initial: _____

Last name: _____ Preferred name: _____

Date of birth: _____/_____/_____ Age: _____ Gender: M / F

Favorite movie: _____

Family's home address: _____

Street City State Zip Code

Who is bringing patient(s) to the first appointment?

Name: _____ Relationship to patient(s): _____

(example: mother, father, step-parent, grandparent, legal guardian, etc.)

1st Parent or Legal Guardian's Information:

Name: _____ Date of birth: _____/_____/_____ Relationship to patient: _____

SSN: _____ Employer: _____ Email: _____

Cell phone #: _____ Other phone # (if applicable): _____

2nd Parent or Legal Guardian's Information:

Name: _____ Date of birth: _____/_____/_____ Relationship to patient: _____

SSN: _____ Employer: _____ Email: _____

Cell phone #: _____ Other phone # (if applicable): _____

How did you hear about our office? _____

If referred by a person, please provide their name so we may thank them!

TURN OVER

Authorization to Disclose Protected Health Information to Family Members and Friends

Patient Name:_____ Date of Birth: ____/____/_____

Patient Name:_____ Date of Birth: ____/____/_____

Patient Name:_____ Date of Birth: ____/____/_____

Patient Name:_____ Date of Birth: ____/____/_____

Patient Name:_____ Date of Birth: ____/____/_____

Patient Name:_____ Date of Birth: ____/____/_____

Patient Name:_____ Date of Birth: ____/____/_____

Patient Name:_____ Date of Birth: ____/____/_____

I hereby authorize Crabtree Pediatric Dentistry to release my child's personal health information (PHI) to the following person (s):
****Please include any person who could potentially bring your child to a future appointment****

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I also authorize this person to accompany my child to dental treatment appointments, schedule future appointments, and review all PHI regarding my child.

Protected Health Information ("PHI") may include information/documents regarding dental/medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments, and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third-party financing.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions, the right to revoke and a description of how I may revoke this Authorization is set forth in the Practice's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature; and that I should send it to the attention of the "HIPAA Compliance Officer". HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of the Practice. Other than those releases authorized by HIPAA, PHI will only be released to the patient, legal parent or guardian, and the persons listed on this authorization.

Signature Patient or Guardian: _____ Date: _____

FINANCIAL POLICY ACKNOWLEDGEMENT

Our practice is proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental care services today. To assist you with your health care investment, we are providing the following payment information and options.

PAYMENT

Payment is due at the time services are rendered. We accept personal checks with the current date, all major credit cards, and debit cards.

All returned checks are subject to a $35.00 returned check fee.

Accounts over 90 days past due will be referred out for collection and the patient is responsible for any fees associated.

INSURANCE

As a courtesy to our patients, we are happy to file your claims to your primary insurance carrier on your behalf. We will make every reasonable effort to collect covered amounts from your insurance company. Deductibles, co-payments and non-covered amounts (including fees above your insurance company's usual and customary fee schedule) are due at the time services are rendered. **All estimates quoted are based upon information provided to us by your insurance company and are estimates only and not a guarantee of payment.** The patient is ultimately responsible for all charges incurred. Insurance companies are required by law to pay or deny claims within 45 days. After 60 days, any unpaid claims will be resubmitted by our office, and we ask that you follow up as well. After 90 days, we ask that you pay in full and have your insurance company reimburse you. We will be happy to provide any information or documentation you may require. Our first and only priority is our patients and the quality of care. The negotiation of benefits is between you, your employer and insurance company.

TREATMENT PLANS

Should your child require dental treatment, these needs will be discussed with you by one of our staff members. In most cases, an additional appointment(s) will be needed to complete the treatment. The payment amount provided to you on the treatment plan is **an estimate only**, and you will be asked to pay the difference between what your insurance company actually paid and the fees incurred at the time of service.

TREATMENT APPOINTMENTS

We do require, at minimum, 24-hour notice for cancellations or reschedules.
If I fail to notify the office prior to the appropriate grace period, I understand that I will be charged $50 per hour of reserved treatment time- not to exceed $200.

CANCELLATIONS

It is the philosophy of our office to provide optimal patient care. All patients are seen by appointment only and are scheduled with your individual needs in mind. This allows us to focus our efforts on caring for and treating our patients to the best of our abilities. We also reserve the right to charge a cancellation fee of **$25** per patient.*

***We require 24-hour notice for cancellations and reschedules. This is necessary to allow us adequate time to notify patients who are on a waiting list for the first available appointment.**
***If 2 broken/missed appointments occur or 2 cancellations without at least 24-hour notice, we reserve the right NOT to schedule any subsequent appointments.**
*** If I fail to notify the office prior to the appropriate grace period, I understand that I will be charged $25 per patient.**

I have read the above and understand and agree to these terms. I hereby authorize the release of any dental information necessary to process insurance claims. I authorize the payment of benefits to be directly to Crabtree Pediatric Dentistry.

_____ _____

Patient/Parent/Guardian Signature Date

TURN OVER

APPOINTMENT POLICY

OFFICE HOURS

Crabtree Pediatric Dentistry

Monday – Thursday: 8:00-5:00

Friday: 8:00 – 1:00

Lunch each day: 1:00 – 2:00

APPOINTMENTS

New Patient/Routine Exams

At all initial and recall exam appointments the following services will be completed for your child: exam, prophylaxis (cleaning), radiographs as deemed appropriate by the doctor for the exam, fluoride treatment, and preventive sealants (as necessary).

Limited/Emergency Exams
Exams due to trauma, pain, or other issues will be scheduled as soon as possible. While we will try and complete necessary treatment during the same appointment, there is no guarantee that work will be able to be done at the same time.

Operative Appointments
We will make every attempt to treat your child in a manner that is safe for not only your child, but also office staff. If we attempt to perform operative treatment on your child and he/she is unable to be treated due to significant uncooperative behavior that cannot be safely managed, a fee will be incurred at the time of the appointment. This fee covers office time, materials, and sterilization.

We reserve the right to schedule certain types of appointments (fillings, extractions, cleanings, etc.) at specific times of the day.

PARENT PARTICIPATION
In our practice, we encourage parent/guardian participation during any appointment. At all times, we request that only **one guardian** accompany the patient into treatment areas to minimize any distractions and maintain patient privacy.

Preventive Appointments
For your comfort a parent or guardian is welcome, but not required, to accompany your child to the hygiene room. We do encourage self-independence to help promote the growth and development of your child.

Operative Appointments
Although it is not recommended, one parent or guardian is allowed in treatment areas during operative procedures if you feel your presence will benefit your child. For the safety of your child, the staff and the doctor, we ask that you assume the role of a silent observer during treatment. All others, including children that are not scheduled at this appointment, are asked to remain in the reception room. Young children in the reception room will need a supervisory adult.

We ask that you refrain from cellular use while in the clinical areas. For the privacy of our staff and doctors, we do not allow videos or pictures to be taken while we are treating you or your child.

I have read and understand the above office policies.

_____ _____

Parent/Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

Crabtree Pediatric Dentistry

3801 W Financial Parkway #101
Rogers, AR 72758
Phone: 479-370-0101 **Fax:** 479-363-5169

Email: info@crabtreepediatricdentistry.com

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health-related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we may share relevant information about your care with your family or friends who are helping you with dental care.

APPOINTMENT REMINDERS: We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to people who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgment

I, _____, have received a copy of the office's Notice of Privacy Practices. I understand the legal duty of Crabtree Pediatric Dentistry's use of and disclosure of health information and my patient rights.

Parent/Guardian Name (Printed) _____

Parent/Guardian (Signature) _____

Patient Name: _____

Patient Name: _____

Patient Name: _____

Patient Name: _____

Patient Name: _____

Patient Name: _____

Patient Name: _____

Patient Name: _____

Should you have any questions or concerns, please let us know.

For Office Use Only

We have attempted to obtain written acknowledgement of the receipt of our Notice of Privacy Practices; however, acknowledgement could not be obtained for the following reasons:

- Parent or Guardian refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency prevented acknowledgement
- Other reason _____

TURN OVER

General Photography/Video Release

I irrevocably grant Crabtree Pediatric Dentistry the right to use my/my child(ren)'s image and name(s) in all forms and media including composite or modified representations for all purposes, including advertising, trade, social media, print, online, video-based marketing materials, other office promotions, and/or other communications. I waive the right to inspector approve versions of my/my child(ren)'s image used for publication or the written copy that may be used in connection with the images.

I release Crabtree Pediatric Dentistry and any assigns, licensees, and successors from any claims that may arise regarding the use of my/my child(ren)'s image, including any claims of defamation, invasion of privacy, or infringement of moral rights, rights of publicity, or copyright. Crabtree Pediatric Dentistry is permitted, although not obligated, to include my/my child(ren)'s name(s) as a credit in connection with the image.

I further acknowledge that my/my child(ren)'s participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in marketing materials or other publications. I acknowledge and agree that publication ofsaid photos confers no rights of ownership or royalties whatsoever.

I understand that this authorization is valid unless I revoke such permission in writing.

Authorization

Patient Name _____

Patient Name _____

Patient Name _____

Patient Name _____

Patient Name _____

Patient Name _____

Patient Name _____

Patient Name _____

_____ _____

Patient/Parent/Guardian Signature Date