



Gilbert A. Trujillo, DDS
Pediatric Specialist

Kellie McGinley, DDS
Pediatric Specialist
Board Certified, Diplomate

Patient Name _____ Date of Birth _____
(please print)

It is the policy of Growing Smiles Pediatric Dentistry, to make confirmation phone calls to patients prior to their appointment. Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), it is necessary for us to get your authorization on certain communication formats. Please see below and mark accordingly.

I authorize the staff of Growing Smiles Pediatric Dentistry to leave a message on my answering machine/voice mail at **home or cell phone** (please circle one or both) regarding:

My child's appointment Yes No My child's dental care/results Yes No

Home Phone _____ Cell Phone _____ Other _____

Also, if I am not available, I authorize the staff of Growing Smiles Pediatric Dentistry to speak with and release information to the following individual(s) regarding:

Name	Relationship	Phone	Appointment	Dental/Results	Account/Billing
			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

I authorize the staff of Growing Smiles Pediatric Dentistry to call my work number, if I am otherwise not available. Yes No
Work Number _____

I authorize the staff of Growing Smiles Pediatric Dentistry to leave a message on my voice mail at my work number. Yes No

I authorize the staff of Growing Smiles Pediatric Dentistry to e-mail me (non-secured) appointment reminders to email address: _____
 Yes No

I authorize the staff of Growing Smiles Pediatric Dentistry to send me a text message to: _____
 Yes No

I understand that it is the policy of Growing Smiles Pediatric Dentistry to take a photo of each patient for their Dental Chart.

I understand this release will remain valid and in place until revoked by me in writing.

Dated this ___ day of _____, 20__.

Parent or Guardian Signature

Date

Parent or Guardian Signature

Date