Welcome to Hometown Children's Dentistry

Account No. ______________________ No. of New Patients ______________

Insurance Co. ______________________ Date ______________

We want to thank you in advance for taking a few moments to fill out our survey. The results will help us determine the best way to get our message of quality pediatric dental care out to the public and to help us better serve the needs of our patients.

How did you hear about us?

__ Sibling or Family Member who is or has been a patient

__ Friend – If so, who may we thank? ______________________________

__ General Dentist Name: ______________________________

__ Pediatrician/Doctor – Name: ______________________________

__ Insurance Co. – Name: ______________________________

__ Health Fair – Name of Fair: ______________________________

__ Education Program School Name: ______________________________

__ Newspaper __ Verizon Yellow Pages __ Yellow Book __ Magnet

__ Sign on building __ Website –www.hometownchildrensdentistry.com __ Sports Club

__ Other: ______________________________

Have you seen our Website? ____ Yes ____ No

If yes, how did you get our website address? __ Yellow Pages __ Newspaper

__ Insurance __ Magnet __ Business Card __ Other: ______________

What were the most important factors in your decision to use our services?

__ Insurance

__ Reputation of doctors

__ Friend's recommendation

__ Pediatric/Special Needs specialist

__ Convenient hours

__ Location

__ Doctor's referral

__ Community involvement

Release of Records Authorization:

Being able to see your child's previous dental records and x-rays allows our dental team to have a better understanding of their overall oral health as well as helping with deciding the right treatment for them!

By signing below, I consent for my previous child's dental treatment records and/or X-rays to be transferred by email to **team@hometownchildrensdentistry.com**

Parent/ Guardian signature:________________________________Date:______________

Please provide the following information if your child is a new patient at Hometown Children's Dentistry and you consent to having their records sent to us from their previous provider:

Previous Dental Practice: ____

Previous Dentist's Name: ____

Previous Dentist's Email Address: ____________________________________

Previous Dentist's Phone Number:____________________________________

Hometown Children's Dentistry

1120 Jacksonville Rd, Ivyland, PA 18974

Medical History Questionnaire:

*THESE QUESTIONS ARE OF GREAT VALUE IN AIDING US TO A BETTER UNDERSTANDING OF YOUR CHILD.

CHILD'S FIRST NAME | CHILD'S LAST NAME | DATE OF BIRTH | MALE | FEMALE

RESIDENCE ADDRESS (STREET) | PHONE

(TOWN) | (ZIP)

SCHOOL | GRADE | REASON FOR VISIT

REFERRED TO THIS OFFICE BY (WE WISH TO THANK THEM).

MEDICAL HISTORY

CHILD'S PHYSICIAN | CITY | DATE LAST SAW PHYSICIAN ______ MONTH / YEAR

	YES	NO
1. IS YOUR CHILD PRESENTLY UNDER THE CARE OF A PHYSICIAN FOR ANY MEDICAL PROBLEM? WHAT?	☐	☐
2. IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION? WHAT?______	☐	☐
3. HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY? FOR WHAT?______	☐	☐
4. IS YOUR CHILD ALLERGIC TO ANY FOOD OR MEDICINE? WHAT?	☐	☐
5. IS YOUR CHILD PREGNANT?	☐	☐

DOES YOUR CHILD HAVE A HISTORY OF? (CHECK YES OR NO)

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	HEART MURMURS	☐	☐	HEARING PROBLEMS	☐	☐	PREGNANCY	☐	☐	CANCER/TUMORS
☐	☐	HEART TROUBLE	☐	☐	DIABETES	☐	☐	CONGENITAL BIRTH DEFECTS	☐	☐	CHEMO/RADIATION THERAPY
☐	☐	RHEUMATIC FEVER	☐	☐	ASTHMA	☐	☐	SPEECH PROBLEMS	☐	☐	LEUKEMIA
☐	☐	ALLERGIES ______	☐	☐	EPILEPSY	☐	☐	ANEMIA	☐	☐	HEPATITIS
☐	☐	ANESTHESIA-ALLERGIC/SENSITIVE	☐	☐	SEIZURES/CONVULSIONS	☐	☐	ADD/ADHD	☐	☐	BLEEDING PROBLEMS
☐	☐	DRUG SENSITIVITIES	☐	☐	RECURRENT HEADACHES	☐	☐	AUTISM/ASPERGER'S	☐	☐	BLOOD DISORDERS
☐	☐	HIGH TEMPERATURE	☐	☐	FRACTURED JAW	☐	☐	AIDS/ARC/HIV	☐	☐	HIGH BLOOD PRESSURE
☐	☐	BRAIN INJURY/CONCUSSION	☐	☐	LUNG TROUBLE/T.B.	☐	☐	KIDNEY/LIVER INVOLVEMENT	☐	☐	HISTORY OF BLOOD TRANSFUSIONS & DATE
☐	☐	VISION PROBLEMS	☐	☐	ARTIFICIAL PROSTHESIS	☐	☐	NERVOUS SYSTEM			
☐	☐	PREMATURE BIRTH									

Is there anything else regarding your child's physical, mental or EMOTIONAL health that you feel we should know? What?

DENTAL HISTORY

CHILD'S FIRST DENTAL VISIT? ☐ YES ☐ NO | PREVIOUS DENTIST | CITY | DATE LAST VISIT | X-RAY DATE

ANY INJURY TO YOUR CHILD'S TEETH OR JAWS? (FALLS, BLOWS, CHIPS, ETC.) ☐ YES ☐ NO | HISTORY OF? ☐ THUMBSUCKING ☐ FINGER SUCKING ☐ LIP SUCKING ☐ NAIL BITING ☐ PACIFIER

HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION FROM PREVIOUS MEDICAL OR DENTAL CARE? ☐ YES ☐ NO | EXPLAIN

HOW DO YOU THINK YOUR CHILD WILL ACT TOWARD THE DENTIST? | AGE OF CHILD WHEN DISCONTINUED BOTTLE OR NURSING.

NAME OF FAMILY DENTIST | CITY

PREVENTIVE DENTAL HISTORY

HOW OFTEN DOES YOUR CHILD BRUSH? | IS TOOTHBRUSHING SUPERVISED? ☐ YES ☐ NO | BY WHOM? | WHEN?

IS DENTAL FLOSS USED? ☐ YES ☐ NO | DOES YOUR CHILD RECEIVE (CHECK). ☐ FLUORIDE IN VITAMINS ☐ FLUORIDE TABLETS/DROPS ☐ FLUORIDATED WATER ☐ NONE ☐ HOW OFTEN?

By signing below, I am acknowledging that all of the information I've provided about my child's health/ medical history is correct to the best of my knowledge:

Parent/ Guardian Signature______________________________ Date:______

CHILD'S INSURANCE INFORMATION

CHILD'S SOCIAL SECURITY NUMBER ______________________

CHILD'S INSURANCE CARRIER ______________________

CHILD'S IDENTIFICATION NUMBER (IF APPLICABLE) ______________________

AUTHORIZATION, FAMILY INFORMATION & FINANCIAL RESPONSIBILITY

RESIDENCE ADDRESS (STREET) (TOWN) (ZIP)			PHONE
PARENT/GUARDIAN'S FULL NAME SOC. SEC. NO. BIRTH DATE:	ADDRESS IF DIFFERENT		OCCUPATION
EMPLOYED BY	BUSINESS ADDRESS	CITY	BUS. PHONE
NAME OF DENTAL INSURANCE CO.	GROUP NUMBER	EMPLOYEE NUMBER	
PARENT/GUARDIAN'S FULL NAME SOC. SEC. NO. BIRTH DATE:	ADDRESS IF DIFFERENT		OCCUPATION
EMPLOYED BY	BUSINESS ADDRESS	CITY	BUS. PHONE
NAME OF INSURANCE COMPANY	GROUP NUMBER	EMPLOYEE NUMBER	
FIRST NAMES OF THE CHILD'S BROTHERS AND SISTERS AND THEIR AGES:			
HAS ANY MEMBER OF YOUR FAMILY BEEN A PATIENT IN THIS OFFICE BEFORE?	YES	NO	IF YES, NAME
IS YOUR CHILD ELIGIBLE FOR STATE/COUNTY AID? YES NO	NAME AND ADDRESS OF CLOSEST RELATIVE OR FRIEND & PHONE NO.		

* IF THE FAMILY IS NOT LIVING TOGETHER, THE PARENT BRINGING THE CHILD IN IS RESPONSIBLE FOR THE CHILD'S ACCOUNT.

I hereby attest, that I am the legal, responsible parent or guardian of the aforementioned child and I hereby agree that I have read the above questions and have filled them out to the best of my ability. I hereby consent to such examinations, diagnostic, and curative treatment, x-rays, local anesthesia, inhalation and oral medication as is necessary upon______________ . If I have any objections to certain aspects of treatment, I have stated so in the space provided below. I will assume responsibility for fees associated with those procedures for my child.

SIGNATURE X	RELATIONSHIP TO CHILD	DATE
DOCTOR SIGNATURE	DATE	

PLEASE NOTE: PAYMENT IS EXPECTED FOR SERVICE RENDERED AT THE TIME OF THE FIRST VISIT. FINANCIAL ARRANGEMENTS FOR SUBSEQUENT TREATMENT MAY BE MADE FOLLOWING THE DIAGNOSIS. THANK YOU.

A CHARGE MAY BE MADE FOR BROKEN APPOINTMENTS UNLESS THE OFFICE IS NOTIFIED 24 HOURS BEFORE APPOINTMENT.

Guardian Authorization Form

If your wish for a person other than your child's parent or legal guardian to bring them to their dental appointment, please sign and provide the following information:

Authorized Person's Name:____________________________________

Authorized Person's Relation to Child:___________________________

By signing below I am giving this person authorization to accompany my child to their dental visit.

Parent/ Guardian Signature:______________________________________Date:______

Please check the following treatments that you agree may be performed in your absence:

Dental Examination: _________

Dental X-rays: _________

Dental Cleaning: _________

Fluoride: ________

Dental Operative procedures deemed necessary by the dentist
(including all restorative procedures: fillings, crowns, extractions) _________

Nitrous Oxide _______

Emergency Treatment__________

By signing below I am agreeing that my child may receive these treatments while accompanied with the person that I have authorized

Parent/ Guardian Signature:______________________________________Date:______

Consent for Dental Treatment:

As the parent and/ or legal guardian of the patient, I do hereby request and authorize Hometown Children's Dentistry and their staff to examine, clean, and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary to diagnose and/ or treat my childs dental problems. I will allow photographs to be taken of my child or my child's teeth for diagnostic and educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment inn terms appropriate for their age. We will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments using a variable voice tone. The usual and most frequent risks or complications occurring from dental treatment include but are not limited to: the possibility of pain or discomfort during or after treatment, swelling, infection, bleeding, injury to adjacent teeth or surrounding tissue, allergic reactions, and jaw pain.

By signing below, I am agreeing that I understand the aforementioned risks that can occur with any dental treatment and agree for the dental professionals at Hometown Children's Dentistry to provide Oral Health Care for my child:

Parent/ Guardian Signature:______________________________________Date:__________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

How we may use and disclose health information about you

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

©2010-2025 American Dental Association

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

By signing this document I am acknowledging that I have reviewed my child's client rights and HIPAA Authorization form:

Parent/Guardian Signature: ______________________ **Date:** __________.

©2010-2025 American Dental Association

COMMUNICATION CONSENTS

Email Consent Form

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Hometown Children's Dentistry offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Hometown Children's Dentistry will use reasonable means to protect the security and confidentiality of email information sent and received. However, Hometown Children's Dentistry cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Hometown Children's Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, have been answered by Hometown Children's Dentistry.

Parent/ Guardian Signature:_______________________________________ Date:_____

Text Message to Mobile Consent Form

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Hometown Children's Dentistry offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Hometown Children's Dentistry will use reasonable means to protect the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclourse of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Hometown Children's Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, have been answered by Hometown Children's Dentistry

Parent/ Guardian Signature:_______________________________________ Date:_____

Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment; It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

Insurance:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to hat benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

Payment:

Please understand that regardless of any insurance status you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to dental fees, operative procedures, tests, office procedures, medications and any other service not directly provided by the dentist.

FULL PAYMENT IS DUE at the time of service. If insurance benefits apply, estimated patient co-payments and deductibles are due at the time of service, unless other arrangements are made

ANY UNPAID BALANCE OVER 90 DAYS OLD will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorney fees, and court costs associated with the recovery of the balance due on this account.

By signing below, I am acknowledging that I have read, understand, and agree to the terms and conditions previously outlined in this document

Parent/ Guardian Signature: ____ Date:_____

Missed Appointment Policy

If you must cancel an appointment, it is required that you call at least 24-hours prior to your scheduled appointment to avoid missed appointment fees. If your child is sick the night before, wakes up sick, or if you have an emergency situation, please call our office immediately and let our receptionist know or leave a message.

Any patient who misses an appointment without giving sufficient notice will be charged a 50$ missed appointment fee.

By signing this document you acknowledge that you have read, understand, and agree to this policy.

Parent/ Guardian Signature: ____ Date: ___

Photography Consent

I, ______________________________________, authorize Hometown Childrens Dentistry to take and/or reproduce photographs/videos of my child/children's teeth or face for publications, presentations, patient testimonials, smile gallery and marketing materials to be used online, social media and/or website.

CONSENT

I acknowledge I have read, and understand the above consent. I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. By signing below, I understand and agree that photographs and videos may be taken of my child/children for educational and marketing purposes. I release Hometown Childrens Dentistry from any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

Parent/ Guardian Signature:____Date:___

Social Media Consent

On occasion, our office will take pictures of patients being treated in our office and dental work that has been performed. The photos are used to promote services available in our practice, for patient education and to demonstrate before and after results of treatment. We would like your permission to use these photos of yourself and your child/children on our website and other social media outlets, in displays in our office and in newsletters.

Upon consent, Hometown Children's Dentistry and its representatives will be released from any claims, including but not limited to claims of invasion of privacy or defamation. It is also acknowledged and agreed that no sums whatsoever will be due as a result of the use of consented photographs or social media materials.

☐ YES, I give my permission for my/my child's photos and other media materials to be used in
displays in the office of Hometown Children's Dentistry
on the website for Hometown Children's Dentistry
on other social media outlets associated with Hometown Children's Dentistry.

☐ NO, I do not give permission for my/ my child's photo to be used on any media outlets

Parent/ Guardian Signature: ____ Date: ___