Sebastian Bouroncle DDS
1900 Opitz Blvd, Ste C, Woodbridge, VA 22191
450 Garrisonville Rd, Ste 201, Stafford, VA 22554
11111 Leavells Rd, Fredericksburg, VA 22407
www.virginianewsmiles.com

CONSENT FOR X-RAYS

The standard of care in our office includes the use of dental radiographs (x-rays). The most common type of x-rays we will take are Full mouth X-ray or Panoramic X-ray and Bitewings, those x-rays are helpful in screening both upper and lower jaws and help diagnose the following:

- Determine missing and existing teeth
- Periodontal conditions (gum and bone disease)
- Abscesses, defects and malignancies of the bones and jaw
- Evaluation of wisdom teeth, health of teeth, roots, crowns, bridges and implants.

These x-rays are usually part of your normal dental hygiene/examination appointments and are necessary to provide the level of diagnosis and care we strive for. At the time of your appointment our staff will notify you if you are due to have x-rays taken. If you have questions or concerns, please feel free to ask any of our staff members.

Patient Signature _____ Date_____

****

HIPAA CONSENT FORM

The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations and describes my rights and the responsibilities and duties of this office with respect to my protected health information.

A copy of The Statement of Privacy Practices is available at my request. Dr. Sebastian Bouroncle reserves the right to change the privacy practices that are described in the Statement of Privacy Practices and I may also obtain a revised Statement of Privacy Practices by request.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

ANY MEMBER OF MY IMMEDIATE FAMILY_____YES_____ NO_____
OTHER (Please specify) _____ YES_____ NO_____

ALSO, I ACCEPT TO RECEIVE COMMUNICATIONS VIA EMAIL AND/ OR TEXT MSG?

YES _____ NO _____

_____	_____	_____
Name of Patient	**Date**	**Signature of Patient or Parent/Guardian**

Sebastian Bouroncle DDS
1900 Opitz Blvd, Ste C, Woodbridge, VA 22191
450 Garrisonville Rd, Ste 201, Stafford, VA 22554
11111 Leavells Rd, Fredericksburg, VA 22407
www.virginianewsmiles.com

REFUSAL OF X-RAYS (ONLY IF YOU REFUSE TO HAVE X-RAYS TAKEN)

I am aware of the X-rays policy for the standard of dental care.
At this time I am choosing to refuse the x-rays that have been recommended to me. I understand that in choosing, my dental/oral health conditions cannot be completely evaluated and diagnosed. This may endanger my dental/oral health as well as my overall health.

Understanding this, I do not hold Dr. Sebastian Bouroncle or any of his staff members liable or accountable for problems that may go undetected as a result of this decision.

Patient Signature_____ Date_____

Printed name_____ Staff Initials_____