North Country Dental Care
Thomas Vigliante, DDS
436 North Country Road · St. James, NY 11780
Phone: 631-584-5605 Fax: 631-862-1186

PATIENT CONSENT & AUTHORIZATION PACKET

Patient Information

Patient Name: _____
Date of Birth: _____
Phone Number: _____

Dental Photography Consent

I authorize Dr. Thomas Vigliante, DDS and/or designated staff to take photographs or video recordings of my teeth, mouth, face, and head. Refusal of optional uses will not affect my dental care.

INITIAL	AUTHORIZATION
_____	Clinical Records & Treatment Planning (required for care)
_____	Professional Education (de-identified use)
_____	Marketing & Promotional Use (website, social media, print materials)

All images are handled in compliance with HIPAA and New York privacy laws. Identifying information will not be used for marketing or educational purposes without express authorization. Consent may be revoked in writing for future use only.

General Dental Consent

I authorize the Doctor to take X-rays, study models, photographs, and any other diagnostic aids deemed appropriate. I further authorize all forms of treatment, medication, and therapy that may be indicated. I understand that the use of anesthetic agents involves inherent risks.

I understand that dental insurance is a contract between myself and the insurance carrier. I am fully responsible for all fees for services rendered, regardless of insurance coverage. Fees are due at the time services are rendered unless prior written financial arrangements have been made. I assign insurance benefits to the Doctor. Any unpaid balance may be subject to late fees as permitted under New York law, and accounts may be referred for collection where appropriate.

Text Messaging & Electronic Statement Consent

I authorize North Country Dental Care to send appointment reminders, billing statements, and other practice-related communications via text message or other electronic means. Message and data rates may apply. I understand that I may revoke this consent at any time by notifying the office.

Patient / Parent / Guardian Signature: _____ Date: _____
Printed Name: _____

By signing above, I acknowledge that I have read, understand, and agree to the consents and authorizations contained in this intake packet.