SPLENDENTAL
Family and Cosmetic Dentistry

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Teledentistry Release Form

I am acknowledging that I wish to receive a teledentistry consultation with my dentist. In the absence of radiographs (x-rays), I understand that I may be asked to send photographs or other documentation as requested by the dentist. I will try to provide as much detailed information as I can. I understand that the doctor is limited to what they are able to determine in these circumstances. I also understand that if I am experiencing pain or swelling that is life threatening, I will call 911 or go to an emergency room. I understand that I am responsible for any payment resulting from this consultation that is not covered by a dental insurance plan. In addition, I understand and consent to this consultation being recorded for clinical documentation and accuracy.

Patient Name:_____ Date:_____

Responsible Party Name (Write "N/A" if Patient):_____

Signature of Responsible Party: _____