



PATIENT INFORMATION: PERSONAL, EMPLOYMENT, AND INSURANCE

Today's Date: _____

Patient Name: _____

LAST FIRST M.I.

(PREFERRED NAME)

Gender (M/F): ___ Marital Status (for computer): [] Married [] Single [] Divorced [] Widowed Birth Date: _____

Driver's License #: _____ Social Security #: _____ email address: _____

Address: _____

STREET

SUITE, APPARTMENT, OR P.O. BOX _____

CITY STATE

ZIP CODE

Phone #'s: HOME (____) - _____ WORK (____) - _____ EXT.____ Best time to call _____

CELL (____) - _____ FAX (____) - _____ PAGER / OTHER (____) - _____

REFERRAL INFORMATION: Whom may we thank for referring you to our office? _____

PRIVACY REQUESTS: This Dental Office respects your privacy. Office operations require basic disclosures, such as mailing bills and contacting you by phone and/or post-cards to advise you of appointments. If you have special privacy requests regarding our contacting you or other concerns, please inform us and we will try (within reason) to comply with your wishes: _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name: _____

LAST FIRST M.I.
(PREFERRED NAME)

Gender (M/F): ___ Marital Status (for computer): [] Married [] Single [] Divorced [] Widowed Birth Date: _____

Driver's License #: _____ Social Security #: _____ email address: _____

Address: _____

STREET

SUITE, APPARTMENT, OR P.O. BOX _____

CITY STATE

ZIP CODE

Phone #'s: HOME (____) - _____ WORK (____) - _____ EXT.____ Best time to call _____

CELL (____) - _____ FAX (____) - _____ PAGER / OTHER (____) - _____

EMPLOYMENT INFORMATION

The following information is for : [] the patient [] the person responsible for payment

Employer Name: _____

Address: _____

STREET CITY STATE ZIP

INSURANCE INFORMATION

First or Primary Insurance

Insured/Subscriber: _____

LAST NAME FIRST NAME M.I.

Subscriber's Birth Date: _____ Subscriber's I.D. #: _____

Subscriber's Address: _____

STREET CITY STATE ZIP

Patient's relationship to Insured/Subscriber: [] Self [] Spouse [] Child [] Other

Insurance Plan Name and Address: _____

Secondary Insurance (if any)

Insured/Subscriber: _____

LAST NAME FIRST NAME M.I.

Subscriber's Birth Date: _____

Subscriber's I.D. #: _____

Subscriber's Address: _____

STREET CITY STATE ZIP

Patient's relationship to Insured/Subscriber: []Self []Spouse []Child []Other

Insurance's Plan Name and Address: _____

CONSENT: By signing this form I consent to this Dental Office's use and disclosure of my records (or my child's records) to carry out treatment, obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to this dental office from my dental care insurance carrier or payor, agreeing that I am financially responsible for payment in full of all accounts. I certify that the above information is complete, accurate, and understood.

PATIENT'S / GUARDIAN'S SIGNATURE: _____ DATE: _____

Patient Please Initial:

I ACKNOWLEDGE THAT I RECEIVED A COPY OF THIS OFFICE'S
' NOTICE OF PRIVACY PRACTICES '

_____ PATIENT'S INITIALS

For Office Use Only:

WE TRIED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR
NOTICE OF PRIVACY PRACTICES

- But: [] Individual refused to sign
 [] Communication barriers prevented
 [] Emergency situation prevented
 [] Individual already has a copy of
 [] Other : _____