PATIENT INFORMATION

PATIENT NAME: ____ PATIENT BIRTHDATE: _____________

ADDRESS: _______________________________ CITY ___________________ STATE ______ ZIP _______

F/T Resident: Y/N **USE FOR CONFIRMATION AND OTHER FORMS OF COMMUNICATIONS:**

HOME PHONE # _________________ E-MAIL ADDRESS: ____

CELL #____________________ TEXT (Y/N) WORK # ______________________(Y/N)

PERSON TO CONTACT IN CASE OF AN EMERGENCY: ____________________ PHONE #_________________

WHOM CAN WE THANK FOR REFERRING YOU? ____

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RESPONSIBLE NAME AND ADDRESS IF DIFFERENT THAN ABOVE:

NAME_____________________________ BIRTHDATE: _________ RELATIONSHIP TO PATIENT: ____________________

ADDRESS: ________________________ CITY: _________________ STATE: ____ ZIP _______ PHONE: ____________

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* Do you have dental insurance? Please provide us with your card and name of policy owner. We will create an insurance claim for you to submit in a stamped envelope provided by our office. Reimbursement will be sent directly to you.

I understand that although I may have insurance, I am the responsible party for this account and will be expected to pay in full at the time of service.

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I hereby give consent for dental treatment for the above named patient. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

To the best of my knowledge, all the answers are correct. If I have any changes in my health or medications, I shall inform my dentist at the next appointment without fail.

I have reviewed the Office Policy and Financial Policy. Initial ____________

I have reviewed the HIPAA Notice of Privacy Practices and Authorization Health Information. Initial _____________

I have reviewed the HIPAA office policy on our Electronic Exchange of Personal Health Information (PHI). Initial ____________

Patient's signature: ____________________________________Date: _______________

COMPLETE HEALTH HISTORY ON REVERSE SIDE