PATIENT INFORMATION

Patient Name: _____ **D/O/B** _____ **Social Security #** _____
Last, First M/I

Gender ___**M** _____**F** **Family Status** _____

Phone (Home) _____ **(Work)** _____ **(Cellular)** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

In case of emergency who can we contact? Name _____ **Phone** _____ **(Relationship)** _____

Name of Pharmacy _____ **Pharmacy Number** _____

***** If Dental insurance applies: Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient. INITIALS of patient*** _____ ****

CONSENT FOR VERBAL RELEASE OF INFORMATION

Please circle where we may leave detailed messages, including appointment reminders and/or detailed test results, Home Cellular Work

***** Answering Machines and voice mail must have an identifying message to confirm these are your numbers for example (You have reached John Doe) *****

Please list any persons with whom we MAY share details about your Dental Health Care.

Name _____ **Relationship** _____

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the Dental Office. I also understand that I will not be able to revoke the consent in cases where the Dentist has already relied on it to use or disclose my Dental Health information. Written revocation of consent must be sent to the Dental office.

Signature of Patient _____ **Date** _____

Printed name of Patient/Parent or Guardian _____

All information written is true and complete _____ **(signature of patient)** _____**Date**

*****HIPPA Acknowledgement of Receipt of Notice of Privacy Practice*******

Please Print Name _____ **Signature** _____ **Date** _____

You may refuse to sign this acknowledgement _____**Signature of patient refused to sign HIPPA**