CONFIDENTIAL INFORMATION

1- Patient Information
Last name_____
First name_____
Preferred name_____
Address_____
City_____St_____Zip_____
Home phone _____ Cell phone _____
Email _____
Preferred method of contact:
□ *Home phone* □ *Cell phone* □ *E-mail*
Date of birth___/___/_____Social Security #_____
Driver's license #_____
(Please✓) □ Male □ Female
□ Single □ Married □ Separated □ Divorced □ Widowed
□ Partnered for _____years
Occupation_____
Business phone #_____ Ext_____
Spouse name_____
Spouse occupation_____
Is another member of your family a patient at our office:
_____
Whom may we thank for referring you to our office?
_____
Name of your dentist _____
Contact for emergency: _____
Phone: _____

2- Responsible party (Please✓) □ same as above
Last name_____
First name_____
Relation to Patient_____
Address_____
City_____St_____ Zip_____
Currently a patient in our practice? (Please✓) □ *Yes* □ *No*
Email _____
Home phone _____Cell phone _____
Date of birth___/___/_____Driver's license #_____
Bank _____
Employer _____
Work phone _____

3- Your insurance carrier
A- Primary dental carrier:
(Please✓) □ yourself; □ your spouse; □ other_____
Date of birth_____ Social Security #_____
Group #_____
Employer_____
Employer Address_____
City_____ State_____ Zip_____
Insurance Co _____
Insurance address_____
City_____ State____ Zip_____
Insurance phone_____

B- Secondary dental carrier:
□ yourself; □ your spouse; □ other_____
Date of birth_____ Social Security #_____
Group #_____
Employer_____
Employer Address_____
City_____ State_____ Zip_____
Insurance Co _____
Insurance address_____
City_____ State____ Zip_____
Insurance phone_____

4- Release of records
Our office requires your authorization for transmitting relevant information (X-rays, photos, records, progress reports or any other appropriate information). I hereby authorize this office to release copies of my records to the following parties: referring dentist, physician, dental specialists, insurance companies. I authorize this office to contact me using an automated calling service and email.

Date: _____ Signature: _____

5- Acknowledgement of receipt of notice of privacy practices
I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Date: _____ Signature: _____

6- Financial Responsibility
As a courtesy to our patients, our office file insurance forms for you. You will be financially responsible for any portion of treatment fees that your insurance plan does not cover. Unless financial arrangements are made, all unpaid balances are due not more than 60 days from the date of service. In some cases, payment in full is required before treatment is rendered. If you want to know in advance your insurance coverage and your own portion, treatment must be delayed until predetermination of your benefit is established.

Date: _____ Signature: _____

7- Persons present during consultation
If you would like anyone, besides your spouse or your parents, to be present during consultation and to be listening to the treatment recommendation, you must inform us in order to comply with **HIPAA** regulations. List of name(s):

_____
_____