

**PATIENT INFORMATION****CONFIDENTIAL**

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

CHECK APPROPRIATE:  MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED  SEPARATED

PATIENT'S OR PARENT'S EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

IF PATIENT IS A STUDENT, NAME OF SCHOOL \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR OFFICE \_\_\_\_\_

PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

**INSURANCE INFORMATION**

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP# \_\_\_\_\_ UNION OR LOCAL# \_\_\_\_\_

**Service Charge**

If I do not pay the entire new balance, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month, which is an annual percentage rate of 18%, applied to the last month's balance.

**Dental Insurance**

I understand that my dental insurance is a contract between the insurance carrier and myself and not between the insurance carrier and the dentist; therefore, **I am still responsible for all dental fees.** I authorize the release of insurance information and benefits to this office.

**PATIENT CONSENT FORM (HIPAA)**

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operation, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to use or disclosure of our personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. I also give consent to receive mail and telephone messages.

**SIGNATURE** X \_\_\_\_\_ **DATE** \_\_\_\_\_