

**Patient Information**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Male \_\_\_\_\_ Female \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Child \_\_\_ Single \_\_\_ Married \_\_\_ Widowed \_\_\_  
If child, parent's names: Mother \_\_\_\_\_ Father \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_  
Cell# \_\_\_\_\_ Work# \_\_\_\_\_, may we contact you at work? Y / N  
Employer \_\_\_\_\_  
Referred By: \_\_\_\_\_

**Person Responsible for account if other than patient**

Responsible party \_\_\_\_\_ Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ Phone # \_\_\_\_\_  
Address if different than above \_\_\_\_\_  
Employer \_\_\_\_\_

**Dental Insurance Policy Holder**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Employer \_\_\_\_\_ Insurance Company \_\_\_\_\_  
Effective Date \_\_\_\_\_ ID # \_\_\_\_\_

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**Patient Consent Form**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- \*Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly & indirectly
- \*Obtain payment from third-party payers
- \*Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name \_\_\_\_\_  
Signature \_\_\_\_\_  
If child, relationship to Patient \_\_\_\_\_  
Date \_\_\_\_\_