PATIENT INFORMATION

Date ______________________

Male_____ Female_____ Minor ____ Single ____ Married ____ Divorced ____ Widowed____

Name ____ DOB _____/_____/______

Address ______________________________________ City _________________ St _____ Zip _____________

Home Phone _________________________________ Cell Phone ____________________________________

Employer ____ Work Phone ______________________________

Employer Address ______________________________ City ________________ St ______ Zip ____________

Soc Sec # _______/_____/__________

Email Address ____

Whom may we thank for referring you? ____

(Ex: Family, Friend, Phone Book, Social Media, On Line Search, Billboard, Mailer, Newspaper, Radio, etc.)

SPOUSE, PARENT, OTHER-Relationship to Patient ____

Name ____ DOB _____/_____/________

Address _____________________________________ City _________________ St ______ Zip_____________

Home Phone __________________________________ Cell Phone ___________________________________

Employer ____ Work Phone _______________________________

Employer Address ______________________________ City ________________ St ______ Zip _____________

Soc Sec # _______/_____/_________

Email Address ____

INSURANCE INFORMATION

Primary Insured Name ____ DOB _____/_____/__________

Employer Name ____

Insurance Company ____

Relationship to Patient __________________________ ID # ____

Secondary Insured Name ____ DOB _____/_____/__________

Employer Name ____

Insurance Company ____

Relationship to Patient __________________________ ID # ____

If Patient is a Student, Name of School/College ____

City ____ St _______ Full time _______ Part time _______

Person to Contact in Case of Emergency ____

Relationship ______________________ Phone _____________________

Non Family Member Contact ____

Relationship ______________________ Phone ____________________

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I request that the following directives be adhered to for the disclosure of my Protected Health Information (PHI). This would include my name, diagnosis, x-rays, test results, date of services and financial information.

You may disclose information to my family members and/or non-family members listed below:

NAME	PHONE NUMBER	RELATIONSHIP

____ You may leave Protected Health Information on my answering machine/voicemail.

Phone Number ____

____ You may leave me a text message. Text Phone Number ___________________________

____ You may email me (unencrypted) for dental appointments.

Email Address ____

____You may fax me for dental information. Fax Number ______________________________

____ You may mail me post cards about my appointment with stated time and date.

____ Other ____

I accept _____ decline _____ a copy of this office's Notice of Privacy Practices.

Print Name ____

Signature ____ Date ___________________________

(Guardian if patient is under 18 years of age)