



Welcome!

| Today's Date: | | | | | | | |
|---|----------------------------------|--------------------------------------|---------------------------------|---|---|---|---|
| PATIENT INFORMATION | | | | | | | |
| Patient's last name: | | First: | MI: | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Marital Status (circle one) Single / Mar / Div / Sep / Wid | |
| Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No | If not, what is your legal name? | | Preferred Name (nickname): | | Birth Date: / / | Age: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| Street Address: | | | Social Security Number: | | Home Phone Number: () | | |
| P.O. Box: | | City: | | State: | | ZIP Code: | |
| Seasonal Home Address: | | | | | | | |
| E-mail Address: | | | | | | | |
| Employer: | | Employer Address: | | | Employer Phone Number: () | | |
| Who may we thank for referring you: | | | | | Cell Phone Number: () | | |
| Other family members seen here: | | | | | | | |
| INSURANCE INFORMATION | | | | | | | |
| Person responsible for bill: | | Birth Date: / / | Address (if different): | | | Home Phone Number: () | |
| Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Employer: | | Employer Address: | | | Employer Phone Number: () | | |
| Are you covered by DENTAL insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Insurance Company Name: | | | | | | | |
| Subscriber's Name: | | Subscriber's Social Security Number: | | Subscriber's Birth date: / / | Group Number: | Subscriber Number: | |
| Patient's relationship to subscriber: | | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other | | |
| IN CASE OF EMERGENCY | | | | | | | |
| Name of local friend or relative (not living at same address): | | | Relationship to patient: | | Home Phone Number: () | Work Phone Number: () | |

ACKNOWLEDGEMENT TO RECEIVE NOTICE OF PRIVACY PRACTICES

In accordance with the privacy law under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, our office must take reasonable steps to limit the use or disclosure of, and requests for, your protected health information. Under this law we are also required to provide you access to our privacy practices, which details how health information about you may be used and how you may access this information.

We ask that you sign below to acknowledge that you have been made aware that you may request a copy of our privacy practices at any time.

Signature

Date