

**PATIENT INFORMATION**

Check all that apply:  Mr.  Mrs.  Ms.  Dr. **AND**  Married  Single **AND**  Male  Female **AND**  Minor

Name \_\_\_\_\_  
Last Name First Name MI Nickname (if applicable)

Address \_\_\_\_\_  
Street Apt. City State Zipcode

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Home Telephone # \_\_\_\_\_  
Month/Day/Year

Place of Employment \_\_\_\_\_ Work Telephone # \_\_\_\_\_

If Full Time Student, School Name \_\_\_\_\_  
 Grade/Year \_\_\_\_\_

Dental Insurance Co.: \_\_\_\_\_ Subscriber # \_\_\_\_\_

Address \_\_\_\_\_ Telephone # \_\_\_\_\_

Has any member of your family ever been treated in our office?  Yes  No

Whom may we thank for referring you:

Yellow Pages  Mailing  Television  Patient \_\_\_\_\_  
 Other \_\_\_\_\_

**FAMILY INFORMATION**

MALE SPOUSE (If patient is married)  
 FATHER (If patient is a minor)

\_\_\_\_\_  
Last Name First Name MI

\_\_\_\_\_  
Address, if different than above State Zip Code

\_\_\_\_\_  
Home Telephone # Work Telephone #

\_\_\_\_\_  
Birth Date (Month/Day/Year) SS#

\_\_\_\_\_  
Employer Position

\_\_\_\_\_  
Dental Insurance Co. Subscriber # Group #

\_\_\_\_\_  
Address

FEMALE SPOUSE (If patient is married)  
 MOTHER (If patient is a minor)

\_\_\_\_\_  
Last Name First Name MI

\_\_\_\_\_  
Address, if different than above State Zip Code

\_\_\_\_\_  
Home Telephone # Work Telephone #

\_\_\_\_\_  
Birth Date (Month/Day/Year) SS#

\_\_\_\_\_  
Employer Position

\_\_\_\_\_  
Dental Insurance Co. Subscriber # Group #

\_\_\_\_\_  
Address

**PERSON TO CONTACT IN EMERGENCY**

Nearest relative not living with you

Name \_\_\_\_\_  
 Relationship \_\_\_\_\_

Address \_\_\_\_\_ Telephone # \_\_\_\_\_

**AUTHORIZATION**

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. The information on this page and the dental/medical histories are accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I grant the right to the dentist to release my

**HIPPA ACKNOWLEDGEMENT**

dental/medical histories and other information about my dental treatment to third party payers and/or health professionals.

X \_\_\_\_\_  
 Adult Patient  Father  Mother  Spouse  Guardian

Date \_\_\_\_\_

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I have received a copy of this office's Notice of Privacy Practices.

X \_\_\_\_\_  
Signature Date

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For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Patient refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other \_\_\_\_\_