

### Patient Information

Chart #.   
FOR OFFICE USE ONLY

Patient Name: \*  \*     
Last First MI Preferred Name

Title:  Gender: \*  Male  Female Family Status: \*  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

Birth Date: \*  SS #:  Prev. Visit:

Email Address:  Best time to call:

Phone: \*        
Home Work Ext Mobile Fax Other

Address: \*    
\*  \*  \*   
City State Zip Code

### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment  neither-not applicable

Name:      
Last First MI Preferred Name

Title:  Gender:  Male  Female Family Status:  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

Birth Date:  SS #:  Driver's License #:

Email Address:  Best time to call:

Phone:        
Home Work Ext Mobile Fax Other

Address:    
    
City State Zip Code

SS# is used for insurance purposes only

### Primary Dental Insurance Information

Name of Insured:     
Last First MI

Insured's Birth Date:  ID #:  Group #:

Insured's Address:    
    
City State Zip Code

Insured's Employer Name:

Employer Address:    
    
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name:

Insurance Address:    
    
City State Zip Code

Do you have Secondary Insurance?

\*  Yes  No

### Secondary Insurance Information

Name of Insured:     
Last First MI

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name:

Whom may we thank for your referral?

\*

## HIPPA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although the revocation will not be effective as to the disclosure of records whose release I have previously authorized or where other action has been taken in reliance on an authorization I have signed. I understand that my healthcare and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

\*  By checking this box, I consent to the practice's use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

## Consent for Services

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I also understand, if applicable, that Associates for General Dentistry is submitting my insurance only as a courtesy to me, and that I am responsible for contacting them, as well as my insurance company, if there are any issues.

\*  I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: \_\_\_\_\_

Date:

Response Date: