

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female

Relation to Patient: _____

SS#/SIN: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street

Apartment #

City

State/Province

Zip/Postal Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street

City

State/Province

Zip/Postal Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

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

Insured's Address: _____

Street

City

State/Province

Zip/Postal Code

Insured's Employer Name: _____

Address: _____

Street

City

State/Province

Zip/Postal Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

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

Insured's Address: _____

Street

City

State/Province

Zip/Postal Code

Insured's Employer Name: _____

Address: _____

Street

City

State/Province

Zip/Postal Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Cancellation Policy:

We charge a \$75 cancellation fee for any appointments cancelled or rescheduled within a 24-hour period of appointment time.

Date: _____

Signature of patient, parent, or guardian

Authorization to Leave Personal Health Information

Federal Law prohibits us from giving any information regarding your health care to any third party or placing such information in a position where it might be discovered by others. This includes leaving messages with any person or a recording device. While leaving such messages might facilitate our ability to contact you, we cannot do so without your specific consent. You may choose to withhold this consent for any reason and without any consequence.

Patient Name: _____ DOB: _____

Please check all that apply:

- May leave detailed message on voicemail at home number: _____
- May leave detailed message on voicemail at Work number: _____
- May leave detailed message on voicemail on cell phone number: _____
- May leave detailed message on a different location number: _____
- May leave information with Spouse (Name): _____
- May leave information with other family member (Name): _____
- May leave information with another person (Name): _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider, should I change one or more of the telephone numbers listed above.

Date: _____

Signature of patient, parent, or guardian

Acknowledge of Privacy Practices

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

- Provide and coordinate my treatment among several health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____