CONFIDENTIAL

We are happy to welcome you to our office! Please completely fill out this form and if you have any questions, we will be glad to help you!

Patient Information

Date____

Patient's last name________________________________ First name______________________ Middle initial_____

Prefers to be called______________________________ Date of Birth ________________ Sex O Male O Female

Social Security# ______________________________ School____

Email address(es) ____

Home address _________________________________ City, State, Zip code______________________________

Home phone ( ) __________________________ Cell phone ( ) ______________________________

Parent / Guardian (if patient is under 18)

Custodial parent(s) name(s)____

Patient lives with (check all that apply) O Mother O Father O Stepmother O Stepfather O Grandparent(s)

O Other____

Primary Guardian Full Name____Date of Birth____________

Occupation________________________________ Email address______________________________________

Address (if different)____

Home Ph. ( )___________________ Cell Ph. ( )___________________ Work Ph. ( )___________________

Secondary Guardian Full Name____Date of Birth____________

Occupation________________________________ Email address______________________________________

Address (if different)____

Home Ph. ( )___________________ Cell Ph. ( )___________________ Work Ph. ( )___________________

Financial Responsibility

Who is financially responsible for this account?____

Address____

City ____________________________________ State___________________________ Zip code_____________

Home phone ( )___________________________ Cell phone ( ) _______________________________

Email address(es)____

Social Security #_______________________________ Employer______________________________________

Who will be responsible for bringing the patient to appointments? __________________________________

Dental / Orthodontic Insurance

Primary policy holder's full name____ Date of Birth____________

Social Security #______________________________ Relationship to patient____________________________

Address and phone (if not listed above)____

Employer____ Address_____________________________________

Insurance company ____________________________ Group #____________________ ID#__________________

Does this policy have orthodontic benefits? O Yes O No O Don't Know

Secondary policy holder's full name____ Date of Birth____________

Social Security #______________________________ Relationship to patient____________________________

Address and phone **(if not listed above)**____

Employer____ Address_____________________________________

Insurance company ____________________________ Group #____________________ ID#__________________

Does this policy have orthodontic benefits? O Yes O No O Don't Know

Medical / Vision Insurance

Primary policy holder's full name________________ Date of Birth________
Social Security #________________ Relationship to patient________________
Address and phone (if not listed on front.)________________
Employer________________ Address________________
Insurance company ________________ Policy #________________ ID#________________

Secondary policy holder's full name________________ Date of Birth________
Social Security #________________ Relationship to patient________________
Address and phone (if not listed on front.)________________
Employer________________ Address________________
Insurance company ________________ Policy #________________ ID#________________

Physician

Patient Physician ________________ City, State________________
Last seen________________ Reason________________ Next appointment________________
Most recent physical exam________________

Other physicians/health care providers being seen now:
Name________________ City, State________________
Reason________________
Name________________ City, State________________
Reason________________

Notice of Privacy

Acknowledgment of Receipt of Notice of Privacy Practices Posted. Copies available upon request.

I have read over this office's Notice of Privacy Practices records and materials.

X ________________ ________________
Patient/Guardian Signature Date

------------------------------ For Office Use Only ------------------------------

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

( ) Individual refused to sign ( ) Communication barriers prohibited obtaining acknowledgment.

( ) An emergency situation prevented us from obtaining acknowledgment. ( ) Other (Specify) ________________

Authorization

I authorize the Provider to release any information including the diagnosis and records of treatment or examination rendered to the patient during the period of such are to third party payers and/or other health practitioners. I authorize and request my insurance company to assign benefits and pay directly to the Provider or Provider's group those insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I authorized the use of my signature on all insurance submissions. I agree to be responsible for payment of all services rendered on my behalf or my dependents

X ________________ _
Patient/Guardian Printed Name
X ________________ ________________
Patient/Guardian Signature Date