PATIENT INFORMATION

PATIENT NAME	RESPONSIBLE PARTY
DOB SEX F M SS#	DOB SEX F M SS#
ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP
HOME PHONE CELL PHONE	PHONE
EMERGENCY NAME & NUMBER	PHARMACY NAME
INSURANCE ID#	PHARMACY PHONE

EMPLOYER	
EMAIL	

AUTHORIZATION AND RELEASE

To the best of my knowledge, the information reported on this form is complete and correct. I understand it is my responsibility to notify the office if any changes in this information occurs. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I grant my permission to contact me at home, on my cellphone, or at my workplace to discuss matters related to my treatment or account. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to
privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple Healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers

- Conduct normal healthcare operations such as assessments and physician certifications

NOTICE OF PRIVACY

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practice

INFORMED CONSENT FOR DENTAL TREATMENT

I understand I'm having any or all of the following done today: Exam, Radiographs and
Cleaning.
I understand that antibiotics, analgesics "Pain Medicine", anesthetics and other substances can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, vomiting and/or more severe allergic reactions.
I understand that during any dental treatment, especially while working on the teeth, it may be necessary to change and/or add procedures because of other discovered unforeseen condition not detected during the initial examination. I give my permission to the Dentist to make any changes, additions and/or deletions, as Dentist deems necessary.

Date: _____Signature of Patient/Legal Guardian: _____

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