PATIENT INFORMATION (Confidential)

Patient Name - First ______________ Middle ______________ Last _____________________ Sex M___ F___ Birth Date ___________

Address ____ Home Phone: _____________________

City ____ State _________ Zip Code _____________

Please circle one: Minor Single Married Divorced Widowed Separated

If Full Time Student, Name of College ____

Relationship to Patient ____

Address, if different ____

Patient or Parent's Employer ____

Work Phone: _______________________________________ Cell Phone: _______________________________________

Email: ____

If you are a new patient, when was your last dental visit?____

WHOM MAY WE THANK FOR REFERRING YOU? ____

DENTAL INSURANCE INFORMATION **Family or Single**

Name of Insured ____

Relationship to Patient ____

Birth Date ______________________ Social Security # ______________________________________

Name of Employer ____ Work Phone _______________

Insurance Company ____ Union or Local #_______________

Insurance Company Address ____

City ____ State ___________ Zip Code ___________

Group # ____ Policy ID # ____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ___ Yes ___ No Family or Single

If yes, complete the following:

Name of Insured ____

Relationship to Patient ____

Birth Date ______________________ Social Security # ______________________________________

Name of Employer ____ Work Phone _______________

Insurance Company ____ Union or Local #_______________

Insurance Company Address ____

City ____ State ___________ Zip Code ___________

Group # ____ Policy ID # ____

HIPPA

A copy of Community Dental's Notice of Privacy Practices has been made available.

We may use and disclose health information about you for treatment, payment, and healthcare operations.

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify)

Signature ____ Date ______________________

If minor, signature of parent or guardian ____

Relationship to patient ____________________________________

OVER