INFORMATION FORM

Date________________

Last Name____________________ First____________________ Birth Date____________

Address____________________ City/Zip____________________ Marital status______ M,S,D,W

Phone____________ Cell Ph.____________ Work Phone____________

Employer/School____________________ Occupation/Student____________________

Employer's Address____________________ City/Zip____________________

Spouse's Name____________ Employer____________ City/Zip____________

Nearest Relative____________ Home Phone____________ Work Phone____________
(not living with you)

Address____________________ City/Zip____________________

For New Patients

Former Dentist____________ City____________ Date of last dental visit____________

Driver's License Number____________ Who is financial responsible for your dental treatment? ____________

Whom may we thank for referring you to us? ____________________

For Patients with Dental Insurance - We may ask to see and copy your insurance card

Insured Person's Name____________ Soc. Sec. No. or Insurance I.D. Number____________

Insurance Co.____________ Group Number____________ Ins. Co. Phone____________

Spouse's Dental Insurance____________ SSI or Insurance I.D. Number____________ Date of birth____________

Name of Plan____________ Group Number____________ Ins. Co. Phone____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign below to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

______________________________ ______________

Patients Signature or Signature of Patient's Representative *Date*

CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

By signing this form, you grant us consent to use and disclose your protected health care information for the purpose of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. You are entitled to a copy of the consent form after you have signed it.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon the Consent. You should also understand that if you revoke this Consent we may decline to treat you.

I have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

______________________________ ______________

Patient's Signature or Signature of Patient's Representative *Date*