THE DENTAL EXPERIENCE

Patient Name: (Last, First) ______________________

Male / Female Phone# (H) ____________ (C) ____________

DOB: ____________ Social Security# ____________

Address: ____________ City: ____________ State: ______ Zip: ______

Primary Insurance name: ____________

Name of insured: ____________

DOB: ____________ Email: ____________

Relationship to Patient: ____________ Phone # ____________

Secondary Insurance Company Name: ____________

Name (Last, First) ____________ DOB: ____________

SS# ____________ Relationship to Insured: ____________

Group/Employer's Name: ____________ Insurance Plan# ____________

Consent

I, the undersigned, herby authorize the Doctor to take x-rays, study models, photographs or any other study aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. I also authorize the Doctor to preform dental treatment, medication, and therapy that may be indicated. I also understand that all dental procedures and the use of anesthetic agents carry a certain risk.

HIPAA acknowledgment and Consent

I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information , in addition , by signed below, I hereby consent to the use of an disclosure of my heath information may be used and disclosed by the office and how I may obtain access to and control this information for addition, by signed below, I hereby consent to the use disclosure of my health information for treatment purposes, payment activities, and healthcare operations as described in the notice.

Authorization, release, and Agreement to pay for the services rendered

I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health practitioners to the extent necessary to determine liability for payment and to obtain reimbursement.

I understand that I am financially responsible for all charges: any deductible amount, co-insurance, or any balance paid for by my insurance company (If I may have one). Based on insurance information provided by myself, the office manager can prepare a treatment estimate reflecting estimated patient portion paid at the time of services in order to control cost of billing, estimate patient portion paid at the time of service is requested.

My signature below is my acknowledgement and consent to the above.

Patient/Guardian Signature ______________________

Date ____________