Stephen Christy, DMD, LLC

PATIENT INFORMATION

Patient name _____

Birthdate _____ **Social Security #** _____

Address _____

City, state, zip code _____

Home phone # (____) _____ **Work #** (____) _____

Cell phone # (____) _____ **E-mail** _____

How did you hear about our office? _____

INSURANCE PAYMENT AUTHORIZATION

Is the patient also the employee/subscriber of the insurance? (circle one) YES NO

If yes, please skip to the bottom of the form to sign.

If no, what is the employee/subscriber name _____

Their birthdate _____ **Their social security #** _____

Their address (if different from the patient's) _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES (NOTICE OF HIPAA)

I have been informed of (or read the copy of) the office's Notice of Privacy Practices. I authorize release of any information to my insurance carrier relating to my dental claims with reimbursement to be paid to the above named dentist. I understand I am responsible for any charges not covered by my insurance.

Signature of patient or guardian (if patient is a minor)

X _____ **Date** _____