

PATIENT INFORMATION-ADULT

NAME: _____
Last First M.I. PREFERRED

ADDRESS: _____
Street City State Zip

DATE OF BIRTH _____ SS# _____ SEX: M F MARITAL STATUS: SINGLE MARRIED OTHER

HOME PHONE _____ CELL PHONE _____ EMAIL ADDRESS _____

CIRCLE HOW YOU WOULD LIKE US TO CONFIRM APPOINTMENTS? CALL HOME, CALL CELL, TEXT OR E-MAIL
**IF YOU WOULD LIKE US TO CONFIRM BY TEXT PLEASE PROVIDE YOUR CELLULAR CARRIER _____

ACCOUNT INFORMATION

PATIENT EMPLOYMENT INFORMATION:

EMPLOYER _____

EMPLOYER'S ADDRESS _____

WORK PHONE # _____

DENTAL INS. WITH THIS EMPLOYER ___Y___N

COVERAGE IS ___ PRIMARY ___ SECONDARY

INSURANCE CO. _____

GROUP# _____

ADDRESS _____

SPOUSE'S NAME _____

SPOUSE'S EMPLOYER _____

EMPLOYER'S ADDRESS _____

WORK PHONE # _____

DENTAL INS. WITH THIS EMPLOYER ___Y___N

COVERAGE IS ___ PRIMARY ___ SECONDARY

INSURANCE CO _____

GROUP# _____

ADDRESS _____

SS# _____ DATE OF BIRTH _____

AUTHORIZATION AND RELEASE:

I certify that the above information and my protected health information contained on the attached dental and medical history are complete and accurate.

I authorize the dentist to perform diagnostic procedures and treatments as may be necessary for proper dental care. I understand that it is my responsibility to follow through on proper dental care as advised by my dentist both before and after treatments.

I consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care activities including the administration of claims for insurance benefits.

I authorize release of my protected health care information, advice and treatment to other health care providers.

I hereby authorize payment of insurance benefits directly to Hart & Olson Family Dentistry, SC otherwise payable to me.

I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual fee for services. I understand that I am financially responsible for payment in full on my account. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole or part by my dental care payer. I acknowledge receipt of the office Financial Policy.

I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that by signing this form, I am giving my consent to your use and disclosure of my protected health information as described above. I also understand I can revoke this consent at any time with written notice to this office.

PATIENT'S SIGNATURE _____ DATE _____