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 ____________