Getting To Know You As Our Patient

Patient Name	Home Address	City, State, Zip
Home Phone	Social Security No. Driver's License No.	Birthdate
Cell Phone	Email	Sex (Circle One): Male Female
Work Phone	Marital Status (circle one): Single Married Divorced Other	Contact Preferences (circle all that apply) Email Text Phone

Insurance: □ **I have secondary insurance. (Please ask us for the secondary insurance form)**

Primary Insurance Company	Group No.	ID No.

Insurance Subscriber Information (if different from patient):

Name	Home Address	City, State, Zip
Home Phone	Social Security No.	Birthdate
Cell Phone	Driver's License No.	Sex(Circle One): Male Female
Work Phone	Email	Relation to Patient:
Employer	Marital Status (circle one): Single Married Divorced Other	Occupation

Responsible Party (if different from above):

Name:	Birthdate:
Social Security No.	Driver's License No.

How did you hear about our office? _____

Communication and Release

I hear by authorize and request any exam, x-rays, or diagnostic aids deemed necessary to make a thorough diagnosis. I consent to the use of these by the doctor for scientific papers or demonstrations. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and employ such assistance as necessary. I agree to the use of anesthetics, sedatives, and other medications as necessary and understand that using these embody certain risks. I understand that I can ask for a complete recital of any possible complications.

I acknowledge that I have reviewed the Notice of Privacy Policies, can get a copy upon request, and consent to the use of my Personal Health Information for the purposes of healthcare operations, treatment, and payment activities.
I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment. I understand if I miss or cancel an appointment with less than 48 hour notice, there will be a failed appointment fee of $50/hour booked, which I agree to pay before any further appointments can be made.

_____ _____

Patient/Parent/Responsible Party (I have read and agree to the content, terms, and conditions listed above) Date