FAMILY 1ST DENTAL

PATIENT INFORMATION

Minor ____ Single ____ Married ____ Divorced ____ Widowed____ Date _____

Name _____ DOB _____/_____/_____

Address _____ City _____ St _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Employer Address _____ City _____ St _____ Zip _____

Social Sec # _____/_____/_____

Email Address _____

Whom may we thank for referring you? _____
(Ex: Family, Friend, Phone Book, Social Media, On Line Search, Billboard, Mailer, Newspaper, Radio, etc.)

SPOUSE, PARENT, OTHER-Relationship to Patient _____

Name _____ DOB _____/_____/_____

Address _____ City _____ St _____ Zip_____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Employer Address _____ City _____ St _____ Zip _____

Social Sec # _____/_____/_____

Email Address _____

INSURANCE INFORMATION

Primary Insured Name _____ DOB _____/_____/_____

Employer Name _____

Insurance Company _____

Relationship to Patient _____ ID # _____

Secondary Insured Name _____ DOB _____/_____/_____

Employer Name _____

Insurance Company _____

Relationship to Patient _____ ID # _____

If Patient is a Student, Name of School/College _____

City _____ St _____ Full time _____ Part time _____

Person to Contact in Case of Emergency _____

Relationship _____ Phone _____

Non Family Member Contact _____

Relationship _____ Phone _____

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I request that the following directives be adhered to for the disclosure of my Protected Health Information (PHI). This would include my name, diagnosis, x-rays, test results, date of services and financial information.

You may disclose information to my family members and/or non-family members listed below:

NAME	PHONE NUMBER	RELATIONSHIP

____ You may leave Protected Health Information on my answering machine/voicemail.

Phone Number _____

____ You may leave me a text message. Text Phone Number _____

____ You may email me (unencrypted) for dental appointments.

Email Address _____

____You may fax me for dental information. Fax Number _____

____ You may mail me post cards about my appointment with stated time and date.

____ Other _____

I accept _____ decline _____ a copy of this office's Notice of Privacy Practices.

Print Name _____

Signature _____ Date _____

(Guardian if patient is under 18 years of age)