NEW PATIENT INFORMATION

Patient Name______________________________ Date of birth ____________ Gender M F

Home Address____

Phone ______________________________ Email Address______________________________

May we confirm appointments by text? YES NO If YES, preferred number: ____________________

May we confirm appointments by email? YES NO If YES, preferred email: ____________________

Do we have your permission to leave a detailed message on the phone numbers listed? YES NO

Please circle one of the following ____ Married Single Divorced Widowed Separated Partnered Minor ____

Employer (if applicable) ________________________ Occupation ____________________ Phone ____________

Emergency contact ____________________ Relationship to patient ________________ Phone ____________

How did you hear about us?____

Please list any other people who you would like us to share patient PHI with and allow them to accompany the patient to appointments:

Name ________________________________ Relationship to patient ____________________

Name ________________________________ Relationship to patient ____________________

Name ________________________________ Relationship to patient ____________________

Name ________________________________ Relationship to patient ____________________

Protected Health Information ("PHI") may include information/documents regarding dental/medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing.

PLEASE COMPLETE IF PATIENT IS UNDER THE AGE OF 18

Mom/Stepmom/Guardian Name______________________Occupation______________Phone____________

Dad/Stepdad/Guardian Name______________________Occupation______________Phone____________

Who has legal custody of patient? ____ Mom Dad Both Other ______________________________

Who is the person responsible for this account? ______________________________________

Preschool/School ________________________ Grade ____________ Homeschooled N/A

________________________________ ____________________

Patient/Parent/Guardian Signature Date

7/31/2018