the PLANO DENTIST

Patient Information

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed

First Name	Middle Name	Last Name	Preferred Name
Home Address	City	State	Zip
Social Security Number		Drivers License Number	Date of Birth
Home Phone	Cell Phone	Email	
Occupation	Employer Name	Employer Phone	
Employer Address	City	State	Zip

Person Responsible For Account ~ ☐Check Here If Same As Above

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed

First Name	Middle Name	Last Name	Preferred Name
Home Address	City	State	Zip
Social Security Number		Drivers License Number	Date of Birth
Home Phone	Cell Phone	Email	
Occupation	Employer Name	Employer Phone	
Employer Address	City	State	Zip

Dental Insurance Information

☐Check here if you do not have Dental Insurance ☐Check here if you previously provided information

Insured's First & Last Name	Date of Birth	Social Security
Name of Insured's Employer		Patient Relationship To Insured
Insurance Company	Phone	Subscriber ID #	Group ID #
Insurance Company Address	City	State	Zip

Referral Information

How did you first hear about our office? ☐Another Patient (relative) ☐Another Patient (friend) ☐New Patient Flyer

☐Another Dental or Medical Office ☐School ☐Work ☐Church ☐Drive By Office ☐Google ☐Yelp ☐Yahoo

☐Yellow Pages ☐Employee ☐Community/Charity Event ☐Insurance Company ☐Health/Benefits Fair or Event

If you were referred to us by someone please write their name.

the PLANO DENTIST

Informed Consent For Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information may be used to:

- Conduct, plan, direct my treatment, and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. My signature will also serve as a release should I request treatment or radiographs be sent to other attending Doctors in the future.
- Obtain payment from third-party payers in your behalf, ie... dental insurance.
- Conduct normal healthcare operations such as quality assessments and required local/federal certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, financial or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize The Plano Dentist and its employees to contact me with information regarding my dental appointments, treatment, billing, health, and services.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Please list any other parties who can have access to your dental information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have been informed & consent to these notices & release information to the above person(s)

_____
Patient Name

_____
Patient/Guardian Signature Date