



**Responsible Party Information (If different from patient info.)**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_

Husband    Wife    Mother    Father    Legal Guardian    Other \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_

Employer's Name \_\_\_\_\_ Work # \_\_\_\_\_ Ext. # \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Primary Dental Insurance** Patient's relationship to insured:  Self    Spouse    Child    Other \_\_\_\_\_

Insurance Plan Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Group Name \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber ID # or Social Security # \_\_\_\_\_

Name of Subscriber \_\_\_\_\_ Subscriber's Birth Date \_\_\_\_\_

Subscriber's Home Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_

Subscriber's Employer Name \_\_\_\_\_ Phone # \_\_\_\_\_

**Secondary Dental Insurance** Patient's relationship to insured:  Self    Spouse    Child    Other \_\_\_\_\_

Insurance Plan Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_

Subscriber ID # for Social Security # \_\_\_\_\_

Name of Subscriber \_\_\_\_\_ Subscriber's Birth Date: \_\_\_\_\_

Subscriber's Home Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_

Subscriber's Employer Name \_\_\_\_\_ Phone # \_\_\_\_\_

**HIPAA** Notice of HIPAA Privacy Practices is clearly posted in our waiting room as prescribed by law. Signature on this form is your acknowledgment of receipt that our office strictly adheres to the federal law as outlined on HIPAA Privacy Form **Consent for Services**: As a condition of your treatment by this office, payment is due at the time service is rendered. Patients with dental insurance are required to pay their estimated portion. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Our office as a courtesy will file claims with the dental insurance company. However, our office cannot render services on the assumption that our charges will be paid by the insurance company. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

**Cancellation Policy**: Our office requires that a 48 hour notice be given for cancellation of an appointment to avoid a broken appointment charge. A fee will be assessed for late cancellation and broken appointments. **To the best of my knowledge, all of the preceding answers and information provided are true and correct. The doctors will be informed, without fail, of any changes in my health. I have read the above conditions of treatment and payment and agree to their content.**

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Patient, Parent and/ or Legal Guardian**