PATIENT INFORMATION

Date_____ Social Security # _____

Patient Name _____
Last Name First Name Middle Initial

Address_____

City _____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthday _____

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced

Patient Employer_____ Occupation_____

How did you hear about us? ☐ Website ☐ Phonebook

☐ Current Patient _____ ☐ Other_____

Home Phone (_____)_____ Cell Phone (_____)_____ Text ☐ Yes ☐ No

Work Phone _____Ext._____ Email_____

Best time to reach you?:_____ Confirm appointments by email? ☐ Yes ☐ No

Emergency Contact Name_____ Relationship_____ Phone_____

PRIMARY INSURANCE

Subscriber Name_____
Last Name First Name Middle Initial

Relation to Patient_____ Birthdate_____ SS#_____

Address (if different than patient) _____

City _____ State_____ Zip_____

Primary Insurance Employer_____ Dental Insurance Company_____

Group/Plan #_____ Member/Subscriber ID# _____

Insurance Company Customer Service Phone _____

ADDITIONAL INSURANCE

Is patient covered by additional dental insurance? ☐ Yes ☐ No

Subscriber Name_____ Relation to Patient_____ Birthdate_____

Address(if different than patient)_____

City _____ State_____ Zip_____

Secondary Insurance Employer_____Secondary Dental Insurance Co._____

Group/Plan #_____ Member/Subscriber ID# _____

Insurance Company Customer Service Phone _____

Marcella and Sid Sockwell, DDS.

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address:

I have received a copy of the Notice of Privacy Practices for Marcella and Sid Sockwell, DDS.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

_____

☐ Other

_____

_____

Prepared By _____

Signature _____

Date _____

Marcella and Sid Sockwell, DDS.

Authorization for Release of Information

Name of Patient _____

Date of Birth _____

Dr.'s Marcella and Sid Sockwell, DDS. are authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab test/x-rays ☐ Other
☐ Spouse (provide name)	☐ Financial ☐ Medical as follows:
☐ Parent (provide name)	☐ Financial ☐ Medical as follows:_____
☐ Other (provide name)	☐ Financial ☐ Medical as follows:_____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or Copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
This authorization shall be in effect until revoked by the patient.

_____Date _____
Signature of Patient or Personal Representative
Description of Personal Representative's Authority (attach necessary documentation)