DENTAL HEALTH CENTER

22216 Loop 494
New Caney, TX 77357
Phone: (281) 354 – 2244

So we may provide you with the best possible care, it is important that you answer the following information as completely as possible. This information is confidential between you and our dental office. Thank You.

PATIENT INFORMATION

Patient Name: ______________________________

Date of Birth ______________ ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

SSN# ______________ Driver's License# __________

Whom may we thank for referring you to our office?

____

CONTACT INFORMATION

Email______________________________________

Mobile # ______________ Home # ____________

Physical Address_____________________________

City ____________ State _____ Zip Code ________

If mailing address is different from physical address please list below:

Mailing Address ____________________________

City ____________ State _____ Zip Code _______

EMERGENCY CONTACT

If patient is a minor, please do not include yourself if you are the person bringing the patient or filling out this form.

Emergency Contact Name ___________________

Phone # ____________ Relationship __________

RELEASE OF PATIENT INFORMATION

If you wish the release of patient information, please list the names of the persons below.

____
Name Relationship

____
Name Relationship

____
Name Relationship

NOTICE OF PRIVACY PRACTICES (HIPAA)

By my signature I understand this office will maintain my healthcare information confidential. My information may be disclosed or used for treatment, payment, insurance or healthcare operations.

____
Signature Date

For office use only
We attempted to obtain written acknowledgement, but it could not be obtained because:

- Patient/Parent or Guardian refused to sign
- An emergency situation prevented us from obtaining it.
- Other (Please Specify): ____________________

INSURANCE INFORMATION

The following information is of the person who is the <u>main policy holder</u>

Name ______________________________________

Birthday _______________ SSN # _______________

Employer Name ______________________________

Insurance Company ___________________________

Insurance Phone # ____________________________

Member ID _________________________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage and assigned to Dental Health Center all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize by my signature for Dental Health Center to submit to my insurance for services rendered at my appointment(s). The office named above may use my healthcare information and may disclose such information to the Insurance Company(ies) named above and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

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Signature Date