FAMILY DENTISTRY
OF HERNANDO, INC.

# PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____ DATE _____

FORM 157290 ITEM 40686

## NAME _____

First, Middle Initial and Last

Street Address

City, State and Zip

Primary Email

Cell Phone | Home Phone

SS# | Date of Birth

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

College Name (if applicable) | City, State and Zip

Full-Time ☐ Part-Time ☐

Employer (Patient/Parent/Guardian) | Work Phone

Business Address | City, State and Zip

Spouse or Parent/Guardian's Name

Employer | Work Phone

Emergency Contact | Phone

Who may we thank for referring you?

## RESPONSIBLE PARTY

Name of person responsible for account

Relationship to patient

Street Address

City, State and Zip

Driver's License # | SS# | Date of Birth

Employer | Work Phone

Is this person currently a patient in our office? Yes ☐ No ☐

X _____

Signature Of Patient Or Parent If Minor

## INSURANCE INFORMATION

Name of insured

Relationship to patient

Birthdate | SS# | Date Employed

Name of Employer | Work Phone | Union/Local #

Employer Address

City, State and Zip

Insurance Company | Phone | Group #

Policy / ID #

Insurance Company Address

City, State and Zip

Your deductible? | How much have you used? | Max Annual Benefit

Do you have any additional insurance? Yes ☐ No ☐

Name of insured

Relationship to patient

Birthdate | SS# | Date Employed

Name of Employer | Work Phone | Union/Local #

Employer Address

City, State and Zip

Insurance Company | Phone | Group #

Policy / ID #

Insurance Company Address

City, State and Zip

Your deductible? | How much have you used? | Max Annual Benefit

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Our office will assist you in obtaining the maximum benefits specified in your contract with your insurance company. However, your insurance is a contract between you, your employer, and your insurance company. As a courtesy to you, we will file your dental insurance.

Not all necessary dental procedures are covered by all insurance companies. Some insurance companies arbitrarily select certain services they will or will not cover, or cover certain services on a limited basis.

Our office will provide you a treatment estimate which you may use in order to contact your insurance company to verify what and how much they will pay on certain services. If your insurance company does not cover certain procedures, such as, but not limited to, rotary instruments, porcelain butt margins, infection control or sterilization fees, crowns under partial, sealants, bonded/composite resin fillings (due to recent findings that amalgam (silver) fillings are toxic/poisonous to the body, we do not place these fillings in our patients - our office only places bonded/composite resin (white) fillings on all teeth), etc., it is your responsibility to pay for any non-covered or partially covered procedures that your insurance company does not make payment on.

SIGNED _____ WITNESS _____ DATE _____

Patient or Parent/Guardian If Under 18 Years Old

**Patient Consent for the Use and Disclosure of Health Information for Treatment, Payment, Or Health Care Operations**

I, _____. understand that as part of my health care, Family Dentistry of Hernando, Inc., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care, such as referrals,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine health care operations, such as assessing quality and reviewing the competence of staff.

**I understand and have been provided with a *Note of Patient Privacy Practices* that provides a more complete description of information uses and discloses. I understand that I have the following rights and privileges:**

- The right to review the "*Notice*" prior to signing this consent,
- This right to restrict or revoke the use or disclosure of my health information for other uses or purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I further understand that Family Dentistry of Hernando, Inc, reserves the right to change their "notice and practices" in accordance with "45 Code of Federal Regulations, Section 164.520". Should Family Dentistry of Hernando, Inc., change the notice, I may request a copy of any revised notice be sent to the address I've provided via U.S. mail.

**Restrictions:** I request the following restrictions to the use or disclosure of my health information:

Please tell us with whom we may discuss your treatment, payment or health care operation:
Example: spouse (name), children (names), other relatives (names), friends or caregivers (names)

**Messages or Appointment Reminders:**
Messages will be of a non-sensitive nature, such as, appointment reminders.

1. May we leave a message at your **home** using the doctor's/practice name: Yes ☐ No ☐
2. May we leave a message at your **work** using the doctor's/practice name: Yes ☐ No ☐
3. Do not leave a message ☐

I understand that as part of treatment, payment, or health care operations, it may become necessary to disclose health information to another entity, i.e., referrals to other health care providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and **accept** ☐ **decline** ☐ the information of this consent.

FOR OFFICE USE ONLY

☐ "Consent form" received and reviewed by _____ on _____
☐ "Consent form" signature refused by patient. Restrictions added by patient.
☐ "Consent form" rplace in the patient's medical record on _____