Patient Information

Name (First, MI, Last):_____

Circle all that apply: Married Single Minor Male Female

Address: _____ City, State, Zip_____

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Cell:_____ Work:_____

Email: _____

Place Of Employment: _____

Please Name the person responsible for this account and your relationship, if other than

yourself: _____

Emergency Contact: _____ Phone: _____

Who may we thank for referring you to our office? _____

HIPAA Release

I authorize the release of personal information, including diagnoses, records, and examinations rendered to me, as well as insurance claims information.

This information may be released only to your insurance company and other medical professionals. Your personal information will not be used for any other purposes and will remain confidential.

My health records may also be released to:

Spouse_____
Child (ren)_____
Other_____

Sign/Date:_____

**Are you currently or have you in the past been treated for Congenital Heart Defect, Heart Valve Replacement, Bacterial Endocarditis, Joint replacement, or any other medical condition that requires antibiotic pre-medication prior to dental treatment?

Yes No

If yes, please explain: _____