McPherson Dental Care

PATIENT INFORMATION

Patient Name: _____ Birth Date: _____ Today's Date: _____

Male ____ Female ____ Marital Status: Single Married Widowed Other SS#:_____

Mailing Address:_____ City/State/Zip: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____**MAY WE CONTACT YOU BY E-MAIL OR TEXTING?_____YES _____NO**

Parent/Spouse's Name: _____ Phone: _____

Person Responsible for Dental Investment:_____ Relationship to Pt :_____

How did you hear about our office?:_____

DENTAL INSURANCE INFORMATION

DO YOU HAVE MEDICARE INSURANCE?_____YES _____NO

Name of Primary Insured:_____ Relationship to Patient:_____

Date of Birth of Insured:_____ SS# of Insured:_____ ID #:_____

Employer:_____ Group #:_____Ins Phone #:_____

SECONDARY DENTAL INSURANCE

Name of Primary Insured:_____ Relationship to Patient:_____

Date of Birth of Insured:_____ SS# of Insured:_____ ID #:_____

Employer:_____ Group #:_____Ins Phone #:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize and request my insurance company to pay directly to McPherson Dental Care, LLC. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on my dependant(s), at the time of service.

Patient Name:_____ Relationship to Patient:_____

Signature:_____ Date:_____