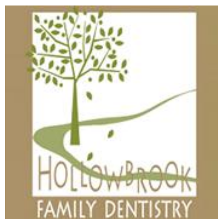

Hollowbrook Family Dentistry

HIPAA PRIVACY PRACTICES

PRINT NAME ____
SIGNATURE ____
Date ______________________

_________Individual refused to sign
_________Communications barriers prohibited obtaining the acknowledgement
_________An emergency situation prevented us from obtaining acknowledgement
_________Other (Please Specify)

DATE ______________________________

PATIENT INFORMATION

NAME ____________________________________ __Married __Single__Minor__Male__Female

SOCIAL SECURITY #__________________________BIRTHDATE___________/_____________/_____________

ADDRESS____
Street Apt# City State Zip

TELEPHONE____
Home Work Cell email

NAME OF EMPLOYER_______________________________________INSURANCE_________________________
PERSON RESPONSIBLE FOR ACCOUNT - Please check one:__Patient __Guardian __ Spouse __Father __Mother

PERSON TO CONTACT IN CASE OF AN EMERGENCY

Name____Telephone_________________________________
Address___________________________________City/State/Zip ____________________________________
Has any member of your family ever been treated in our office: ___Yes ___ No
Who can we thank for referring you to our office?________________________________

AUTHORIZATIONS

I hereby authorize payment directly to the Dental Office of the group insurance benefits, otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals by any method, including electronic transfer.

If your account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, you will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs. You are ultimately responsible for payment on your account. Returned checks are subject to a $26.00 service charge.

Patient or Responsible Party ____