PATIENT INFORMATION

FIRST NAME: _____ **LAST NAME**: _____

ADDRESS: _____ **CITY, STATE, ZIP**: _____

HOME PHONE: _____**WORK PHONE**: _____

CELL PHONE: _____ **E-MAIL**: _____

BIRTH DATE: _____ **SOCIAL SECURITY #:** _____ **DL#:** _____ **EXP**: _____

EMPLOYER: _____ **DENTAL INSURANCE**: YES NO

SEX: MALE FEMALE **MARITAL STATUS:** SINGLE MARRIED DIVORCED SEPARATED WIDOWED

PREFERRED PHARMACY NAME: _____ **LOCATION:** _____

PREFERRED PHARMACY PHONE #: _____

EMERGENCY CONTACT NAME: _____ **PHONE #:** _____

EMERGENCY CONTACT ADDRESS: _____

RELATIONSHIP TO PATIENT: _____

REFERRED BY: **EXISTING PATIENT** **DROVE BY** **INTERNET** **YELLOW PAGES**

PATIENT: _____ **NEWSPAPER AD:** _____

INSURANCE INFORMATION

INSURED NAME: _____ **RELATIONSHIP TO PATIENT**: _____

INSURED DATE OF BIRTH: _____ **INSURED SOCIAL SECURITY #:** _____

INSURED ADDRESS: _____

INSURED HOME #: _____ **WORK #:** _____ **CELL #:** _____

EMPLOYER: _____ **INSURANCE COMPANY:** _____

GROUP #: _____ **POLICY OR ID #:** _____

INSURANCE PHONE #: _____ **MAILING ADDRESS FOR CLAIMS:** _____

_____

HAVE YOU USED ANY BENEFITS THIS YEAR? _____ **WHERE?** _____

THE UNDERSIGNED HEREBY AUTHORIZES AMARILLO DENTURE CLINIC TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S DENTAL NEEDS. I FURTHER AGREE TO ALLOW THE DOCTORS TO USE THE AFOREMENTIONED FOR ANY ACADEMIC REASON AND UNDERSTAND THAT MY IDENTITY WILL BE KEPT PRIVATE AT ALL TIMES. I HAVE HAD THE OPPORTUNITY TO REVIEW A COPY OF THE NOTICE OF PRIVACY PRACTICES AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA").

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ALL DENTAL FEES AND THAT THESE FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE. IF APPTOINTMENT IS CANCELLED LESS THAN 24 HOURS A $52.00 FEE APPLIED TO MY ACCOUNT.

_____ _____

PATIENT SIGNATURE ***DATE SIGNED***