

Green Mountain Dental

ABOUT YOU

Today's Date: ____/____/____

Name: _____

I prefer to be called: _____

SS#: _____

Birth date: _____ Age: _____

Male Female

Gender Neutral Preferred Pro-noun _____

Home Address: _____

Town _____ Zip Code _____

Cell #: _____

E-mail Address: _____

How do you prefer to be contacted?

E-Mail Phone Text

Employer: _____

Occupation: _____

Single Married Divorced/Separated

Other family members seen by us:

Previous/Present Dentist _____

Last Visit: _____

How did you find out about us?

Friend Family Google
 Facebook Yelp Other

Whom may we Thank for referring you?

SPOUSE INFORMATION

His/her Name: _____

Employer: _____

SS#: _____

Birth date: _____

Person Responsible for Account:

Self Spouse Other (See below)

If Other, please continue:

Name: _____

Cell #: _____

Billing Address: _____

Relation: _____

SS#: _____

INSURANCE COVERAGE

Primary

Dental Coverage: YES NO

Insurance Co.: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Member ID: _____

Group #: _____

Insured's Name: _____

Relation: Self Spouse Child Other: _____

Insured's Birth Date: ____/____/____

Insured's ID/SS#: _____

Insured's Employer: _____

Secondary (if applicable)

Dental Coverage: YES NO

Insurance Co.: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Membership ID: _____

Group #: _____

Insured's Name: _____

Relation: Self Spouse Child Other: _____

Insured's Birth Date: ____/____/____

Insured's ID/SS#: _____

Insured's Employer: _____

EMERGENCY CONTACT

In the event of an emergency, is there some who lives near that we should contact?

His/her Name: _____

Cell #: _____

Relationship: _____

CONTINUE ON BACK

Name: _____ Phone: _____

Address: _____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

CONSENT FOR TREATMENT:

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

YOUR RIGHTS:

You have the right to have access and/or copies of your PHI records at any time. You have the right to request additional restrictions on your PHI, and we will do so unless legally bound otherwise. You have the right to refuse to sign the consent form, or to rescind your consent.

Signature: _____

FOR OFFICE USE:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- An emergency situation prevented us from obtaining acknowledgement
- Other (Specify)