

Dr. Angel Diaz-Norman D.D.S., P.A.

9100 Coral Way

Suite 2

Miami FL 33165

(305)227-4020



Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #.
FOR OFFICE USE ONLY

Patient Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: Male Female Family Status: Married Single Child Other

Birth Date: Prev. Visit: Email Address:

Phone: Home Work Ext Mobile Best time to call:

Address:
 City State Zip Code

Preferred appointment times:

Mon Tue Wed Thur Fri Sat
 Morning Afternoon Evening Any time

Whom may we thank for referring you to our practice?

Dental Office Yellow Pages Internet
 Newspaper School Work
 Other (name below):

Name of person, office, or other source referring you to our practice:

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Consent for Internet Communications

Patient Name:
Last First MI Preferred Name

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature of patient, parent, or guardian:

Signature: _____

Date:

Relationship to Patient:

Response Date:

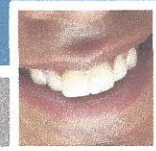
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Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment neither-not applicable

Name:
Last First MI Preferred Name

Title: Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: Email Address:

Phone: Best time to call:
Home Work Ext Mobile

Address:

City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: Phone:

Address:

City State Zip Code

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Primary Insurance Information

Primary Dental Insurance:

Name of Insured:
Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Primary Medical Insurance:

Name of Insured:
Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

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Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured:
Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Secondary Medical Insurance:

Name of Insured:
Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: