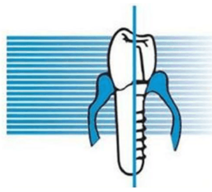

Patient Update

Has there been any change in your health since your last dental appointment?

___ yes ___ no

if so, please explain:

____

____

____

____

Are you taking any new medications?

___ yes ___ no

if so, please explain:

____

____

____

____

HIPAA

Who else may we release information to?

____

Messages

Voicemail:

May we leave a detailed message?

___ yes

___ no, leave a message asking me to return your call

Text Reminders:

___ yes

___ no

Email Reminders:

____

Name: ______________________________

DOB: ______________________________

Address: ______________________________

____

Phone Number: ______________________________

Email: ______________________________

Primary Insurance Co: ______________________

Group # ______________________________

Subscriber ID or SSN: ______________________

Subscriber Name: ______________________

Secondary Insurance Co: ______________________

Group # ______________________________

Subscriber ID or SSN: ______________________

Subscriber Name: ______________________

Assignment & Release

I certify that I, and/or my dependents, have insurance coverage with __________________________. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurances company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____

Signature of patient, parent or guardian

____

Date Relationship to patient

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