

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST
 ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 E-MAIL _____ CELL PHONE _____ HOME PHONE _____
 SS#/SIN _____ BIRTHDATE _____
 CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED
 IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____
 PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____
 BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____
 WHOM MAY WE THANK FOR REFERRING YOU? _____
 PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____
 ADDRESS _____ HOME PHONE _____
 DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____
 EMPLOYER _____ WORK PHONE _____
 IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
 BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____
 NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____
 EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____
 INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
 BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____
 NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____
 EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____
 INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

X _____
 SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR PATIENT NUMBER

Florence Family Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Date of Birth: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Dr. David L. Smith, D.M.D.**

Telephone: **(719)784-3935**

Fax: **(719)784-4686**

Address: **100 S. Pikes Peak Ave Florence, CO 81226**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

