Please Complete Every Section of this form **Patient**:____________________________

INSURANCE INFORMATION:
Please bring your insurance card with you to every visit.
It is your responsibility to contact your insurance company before you arrive for your appointments to verify coverage, and make sure you are aware of what your policy covers or does not cover along with any changes to your policy. Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage.

Name of Insured Employee:____

Employer:_______________________________________Effective date of coverage:________

Insured Social Security or member #:_______________________Birthdate:_______________________

Name of Dental Insurance Company:____

Phone: (   )________________________Group Number:________________________________

Is there any other dental insurance coverage for any of the family members covered under this policy?
_ Yes/No ____*If there is other coverage, please supply that information also on the reverse side*

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES" *

I, ___________________________, have received a copy of this office's "Notice of Privacy Practices."

X __________________________________ ________________________ * you may refuse to

Signature Date sign this acknowledgement

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) ____

INFORMED CONSENT/MODEL RELEASE:

As our patient, you have the right to be informed of your condition as well as the possible consequences of not treating the diagnosed condition. However, to adequately evaluate the existing conditions in your mouth, we require the necessary radiographs so that we may see the current bone levels, any interproximal decay, supernumerary teeth, or other abnormalities that cannot be seen visually. Having been informed of the need for such radiographs, it is your decision whether or not to accept this as part of our examination.

Should you decide not to have the radiographs, as recommended, we cannot be held responsible for any conditions that may exist due to the fact that we cannot diagnose what we cannot see.

For valuable consideration, I irrevocably consent to and authorize the use and reproduction by you, or anyone authorized by you, of any and all photographs, which you have on record of me, negative or positive, for any purpose whatsoever, without further compensation to me. All negatives and positives together with the prints shall constitute your property, solely and completely.

I am over eighteen (18) years of age: Yes or No Patient Signature: **X**________________________________

If the patient is under 18 years of age, a parent or guardian signature:________________________________