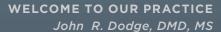




Relationship to Patient

Phone

Patient Information	Primary Insurance Information	
Date	Dental Coverage	
Referred By	Insured's Name	
Patient Name	Relationship to Patient	
Guardian	ID Number	
Street Address	Birth Date	
City	Employer	
State	Insurance Company	
Zip Code	Insurance Group Number	
SSN	Insurance Company Address	
Birth Date		
Age	Insurance Company Phone	
Gender	SSN	
□ Married □ Partner □ Separated □ Widowed □ Single □ Minor	Coopedayy, Incurance Information	
Full Time Student 🗆 Yes 🗆 No	Secondary Insurance Information	
School / Employer	Dental Coverage	
Occupation	Insured's Name	
Spouse's Name	Relationship to Patient	
Employer	ID Number	
	Birth Date	
Contact Information	Employer	
Home Phone	Insurance Company	
Work Phone	Insurance Group Number	
Mobile Phone	Insurance Company Address	
E-mail Address		
	Insurance Company Phone	
Emergency Contact	SSN	
Name		
Address		





## **Acknowledgment of Privacy Practices**

(You may refuse to sign this acknowledgement)
Name (print):
Signature:
Date:
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
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining the acknowledgement
☐ Other (Please Specify)

## **Attention Patients**

It is our responsibility to notify you of the statewide database of controlled substance prescriptions. This database is called the Prescription Drug Monitoring Program or PDMP. The database keeps a log of each patient's history of controlled substance use and allows healthcare providers to view history and dosage of previously used controlled substances.

Your signature on this form only verifies that we have notified you of this program.

Signature	
Date	