RICHARDSON
Dental Center

Age _____

Patient's Name _____ Date of Birth _____ ☐ Male ☐ Female
Last First Initial

How do you wish to be addressed _____

If Child: Parent's Name _____

Single☐ Married ☐ Dependent ☐

Residence: Street _____

City _____ State _____ Zip_____

Home Phone _____ Cell_____

Work Phone _____

Email _____

Patient/Parent Social Security No. _____

Spouse/Parent Social Security No. _____

Patient/Parent Employed By _____

Spouse/Parent Name _____

Spouse Employed By _____

Who is responsible for this account _____

Dental Insurance Carrier(s) _____

Other family members in this practice _____

_____

Whom may we thank for this referral _____

Someone to notify in case of emergency not living with you _____

_____

HIPAA:

*Copy available upon request.

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that I may request in writing that you restrict how my privacy is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that if I have any questions/concerns, I may contact this office's privacy officer.

I authorize messages to be left on my email address and phone numbers provided. ☐ YES ☐ NO

_____ _____
Patient Name Relationship to Patient

_____ _____
Signature Date

I authorize Dr. Richardson and or his office staff to discuss my treatment and financial arrangements with the following people:

☐ Spouse: _____ ☐ Children:_____
Name Name

Name of others: _____

_____ _____
Patient Name Signature

*This HIPAA authorization is good for 3 years.

Consent:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous payments agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

_____
PATIENT OR GUARDIAN SIGNATURE

Date_____