# STEVEN TAM, DMD,

**Patient Information** 病人信息/ 病人信息

Last Name 姓 ______________________ First Name 名字 ______________________ MI ______

Date of Birth 生日 ______________ Social Security 工卡 ______________________ Sex **F 女** **M 男**

Address 地址 ______________________________________________

Phone/ 电话/ 電話 ______________________ Mobile/ 手机/ 手機 ______________________

Email 郵件/郵件 ______________________________________ Can we text? _______

Pharmacy Name 藥房名 ______________________ Phone 电话/ 電話 ______________________

Emergency Contact
**紧急联系人/** 緊急聯繫人 ______________________ Phone 电话/ 電話 ______________________

Whom may we thank for referring you to our office?
誰推薦您來我們的辦公室 ______________________________________________

**Insurance Information 保险信息 /保險信息**

Primary Ins Co 主要保险/保險 ______________________ ID# ______________ Group# ______________

Insured party 被保险人 ______________ Relation 關係 ______________ DOB 生日 ______________

Secondary Ins Co 主要保险/保險 ______________________ ID# ______________ Group# ______________

Insured party 被保险人 ______________ Relation 關係 ______________ DOB 生日 ______________

## Authorization and Consent

- I attest to the accuracy of the information on the patient information and Health History Forms. It is my responsibility to inform this office of any changes in my medical status.
- I agree and consent to dental examination by Dr. Tam. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed. I authorized release of any information concerning my health care, advice and treatment to referral providers who assist in the care of my medical and dental treatment.
- I authorize Dr. Tam to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options
- I authorize and request my insurance company to pay my benefits directly to Steven Tam, DMD, PC, otherwise payable to me. I authorize the use of my signature on all insurance submissions. I authorize the release of any information for billing purposes. This consent will remain valid and in effect unless we are otherwise notified in writing. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan.

______________________________________________

**Patient or Guardian's Signature** **Date**

## Notice of Privacy Practices

- By signing below, I acknowledge that I have received Steven Tam, DMD, PC's notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

______________________________________________

**Patient or Guardian's Signature** **Date**

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as requested by law,
But acknowledgement could not be obtained because

Individual refused to sign
Other (specify)
Communication barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgment