A B C

## Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

Cell Phone _____ Email _____

How did you hear about Valley Dental Care? _____

## Responsible Party Information

Name _____
Last First Middle Marital Status

Mailing Address _____
Street City State Zip

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Social Security # _____ Birth Date _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birth Date _____ Work Phone _____

## Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

## Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I hereby consent to dental treatment by Valley Dental Care.

Signature (Parent's signature if minor) _____

_____

CONFIDENTIAL (for record and pretreatment evaluation)

# Valley Dental Care – Patient Consent Form

I consent to receive dental care at Valley Dental Care.

Patient Name (print) _____

Patient/Guardian Signature _____ Date _____

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Please provide your email and cell phone information below so we can ensure your record is up to date.

Patient/Guardian Cell Phone # _____

Patient/Guardian Email Address _____

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## Receipt of Notice of Privacy Practices Acknowledgement Form and Consent for Use and Disclosure of Health Information

Patient Giving Consent:

Name: _____

Address: _____

Telephone: _____

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, healthcare operations, and other uses disclosed in our "Notice of Privacy Practices".

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, and other uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice is provided here with. We encourage you to read it carefully and completely before signing the 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 which will contain the changes.

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 Administrator listed above.

I acknowledge receipt of Valley Dental Care "Notice of Privacy Practices" and have had the opportunity to read and consider the contents of this Consent form and 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 of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____

By signing this consent for you are agreeing that Valley Dental Care can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Signature: _____ Date: _____

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

Name: _____ Relation to Patient _____