## **Patient** The highlighted fields are required

| First Name | Last Name | Middle Initial |
|---|---|---|
| Preferred Name | | |
| Address | | Apartment |
| City | State | Zip Code |
| Birth date | Soc Sec | Drivers Lic |
| Student Status Full time [ ] Part time [ ] Not a student [ ] | School Name | |
| Home Phone | Work Phone | Extension / Cell Phone |
| Marital Status Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] | | |
| E-mail | How were you invited/referred to our practice? | |

## Primary Insurance Subscriber

| Name of Subscriber | Subscriber Birth Date | Subscriber Soc Sec |
|---|---|---|
| Employer | Ins. Company | |
| | Address | |
| | City / State / Zip Code | |
| | Group Number / Subscriber ID / Phone Number | |

**HIPPA Acknowledgement**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at (1205 West Dundee Road, Wheeling, IL 60090) to obtain a current copy of the Notice of Privacy Practices.

I understand that I can request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

| Patient or Legal Guardian Signature | Date |
|---|---|
| Dependent Family members also covered by this acknowledgment: | |
| | |
| | |

For Office Use Only: We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other