Patient Information

Last Name	**First**	**MI**	Cell Phone ( )
SSN	E-Mail		Home Phone ( )
Address			Work Phone ( )
City	State	ZIP	
Male ○ Female ○ Age	Birthdate		○ Married ○ Widowed ○Single
Whom may we thank for referring you?			
Emergency contact			Phone

Primary Insurance

Subscriber Name		
Relation to Patient	Birthdate	SSN
Address (if different from Patients)		Phone ( )
City	State	ZIP
Insured Employer	Insurance Company	
Phone	Group#	Subscriber #

Additional Insurance

Is patient covered by additional dental insurance ○yes ○no

If yes please add additional information on the back this form.

Dental History

Reason for today's visit	Date of last dental care	
Previous dentist	Date of last dental x-ray	
Check if you have had a concerns/interest with any of the following		
○Bad breath	○Food collection between teeth	○ Periodontal treatment
○Bleaching	○Fluoride treatment	○ Sensitivity to hot/cold
○Bleeding gums	○ Grinding teeth	○ Sensitivity to sweets
○Clicking or popping jaw	○Laser dentistry	○ Sensitivity to biting
○Cosmetic restoration	○ Loose teeth or broken fillings	○Sores or growths in your mouth

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Mooney and Holmberg DDS PLLC (Smile for Life)'s Notice of Privacy Practices.

Patient name ____

Signature ____ Date ______________________

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurances.

Signature____Date____________________

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA.

Spouse only ◯Yes ◯NO

OR

Any Member of my immediate family: (i.e. Spouse, Children, Children's Spouses) ◯Yes ◯NO

Any Member of my extended family: (i.e. Parents, Grandchildren) ◯Yes ◯NO

OTHER:

(Name)____________________________________Telephone#:______________________ ◯Yes ◯NO

Name of patient (please print):____

Patient signature (if 18+ years of age):____

Patient's personal representative: (Please Print):____

Personal Representative's signature:____

Representative's Telephone Number:____