PERSONAL INFORMATION (PLEASE PRINT)

Full Name_____ Preferred Name_____
Last Name First Name Middle Initial

Address_____

City_____ State_____ Zip_____ E-mail _____

Home Phone ( ) _____ Wk Phone ( )_____ Cell Phone ( ) _____

Sex M or F Birth date _____/_____/_____ Age_____ SS# _____/_____/_____

Your Occupation _____ Employer/School _____ Employer/School Phone_____

Marital Status ( ) Single ( ) Married ( ) Minor ( ) Separated ( ) Divorced ( )Widow(er) ( ) Partnered

Spouse/Parent Name _____

Spouse/Parent Employee_____ Spouses/Parent Business Phone ( ) _____

Spouse/Parent Social Security # _____/_____/_____ Who is responsible for account? _____

Emergency Contact Name _____ Relationship _____ Phone ( ) _____

Who may we thank for referring you to this office? _____

DENTAL INSURANCE INFORMATION

Primary
Insurance Company Name_____ Phone (_____)_____

Primary Policy Carrier's Name _____

Group # _____ ID# _____

Insurance Company Address _____

City _____ State _____ Zip _____

Secondary
Insurance Company Name _____ Phone ( ) _____

Policy Carrier's Name _____

Group #_____ ID# _____

Insurance Company Address _____

City _____ State _____ Zip _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Plainview Dental, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Patient's/Parent Signature_____ Date_____ Witness _____

Please turn over for more important information that requires your signature. Thank you.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to Plainview Dental ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for the purpose relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on the document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health condition; the provision of health care to me; or the past, present, or future payment for the provision of healthcare services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction of the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand that I have the right to review the Practice Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that a Physician or the Practice has acted in reliance on this consent.

Fees are payable when services are rendered unless other arrangements are made. I, undersigned, hereby authorize the Plainview Dental Dentists , and whomever they may designate as their assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand that The Practice is required to maintain original records and x-ray films as property.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Name of Personal Representative **Personal Representative's Authority**

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Plainview Dental will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

Patient's/Parent's Signature_____ **Date**_____**Witness**_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all Insurance information given to this clinic is correct and complete.

Patient's/Parent's Signature_____ **Date**_____**Witness**_____

REQUEST FOR PAYMENT OF BENEEFITS TO PROVIDER OF CARE

I hereby authorize my insurance company/administrator to pay by check, and for it to be mailed directly to: Plainview Dental, 338 W. Broadway, PO Box 518, Plainview, MN 55964 the expenses benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said professional charges. I agree that this office be given power of authority to endorse/sign my name on any and all drafts for payment of my bill.

CONSENT FOR TREATMENT OF MINOR

I hereby authorize Dentists of Plainview Dental and whomever they may designate as their assistant(s), to perform diagnostic tests, including but not limited to radiography, and to administer treatment as he deems necessary to:

(Child's Name)_____**, my son/daughter/or power of Authorization(circle one).**

Parent's or Guardian's Signature_____**Date**_____**Witness**_____