Athens DENTAL SERVICES

Today's date_____

## PATIENT INFORMATION (Please present your Driver's License and all insurance cards to the receptionist to be photocopied)

Name_____ Name you prefer to be called: _____
Last First Middle

Address _____
Street City State Zip

Date of Birth _____ SS# (required for insurance) _____

Male _____ Female _____ Marital Status (Circle): Single Married Divorced Separated Widowed

Home Phone _____ Cell Phone _____

Work Phone _____ e-mail _____

If patient is age 26 or younger: Student Status: _____ Part-time _____ Full-time School: _____

Your Employer _____ Employer's City/State _____

Spouse's Name _____ Spouse's SS# _____

Spouse's Date of Birth _____

Spouse's Employer _____ Spouse's Work # _____

## RESPONSIBLE PARTY INFORMATION

Person Responsible for Account _____ Relationship to Patient _____

Address/City/State/Zip _____

SS# _____ Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

## PATIENT'S INSURANCE INFORMATION

**PRIMARY** Insurance Company _____

Subscriber Name _____

Subscriber SS# _____

Subscriber Date of Birth _____

Subscriber Employer _____

Insurance I.D. # (if different from SS#)_____

Group # _____

**SECONDARY** Insurance Company _____

Subscriber Name _____

Subscriber SS# _____

Subscriber Date of Birth _____

Subscriber Employer _____

Insurance I.D. # (if different from SS#)_____

Group # _____

## REFERRAL INFORMATION

How did you hear about Athens Dental Services? (Circle) Newspaper TV Internet Referral Other: _____

Who may we thank for referring you to our office? _____
Name

## EMERGENCY CONTACT

Name/Relationship/Phone # of the person who can always reach you: _____

Nearest relative not living with you & phone # _____

Other family members seen by us: _____

The above information is true to the best of my knowledge.

Signature: _____

## Patient Consent for Dental Treatment

1. I authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I hereby give lifetime authorization for payment of insurance benefits to be made directly to ATHENS DENTAL SERVICES for services rendered. I hereby authorize ATHENS DENTAL SERVICES to release all information necessary to secure payment of benefits.
5. ***I understand I am financially responsible for all charges, whether or not covered by insurance. Payment is due at the time of service*** unless other arrangements have been made prior to this appointment. In the event of default, I understand that service charges and court fees may apply and a check of my credit history may be made.

Patient or Responsible Party Signature _____

Relationship to Patient _____

Date _____

## Acknowledgement of Notice of Privacy Practices

I give permission to ATHENS DENTAL SERVICES to release any health information for the stated reasons:

- Referrals to another office (including x-rays)
- To obtain payment of services by filing my insurance
- To call, leave message, or mail reminder cards for upcoming appointments
- To discuss health information for possible treatment, service, or benefits of interest to me, or for evaluation by a staff member
- To disclose information in the event of disaster relief

***You may obtain a copy of NOTICE OF PRIVACY PRACTICES from any staff member.***

I hereby acknowledge that I have had full opportunity to read and consider the content of this office's NOTICE OF PRIVACY PRACTICES. I understand that by signing this Consent form, I am giving my consent to ATHENS DENTAL SERVICES use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

PRINT Patient or Responsible Party Name _____

Patient or Responsible Party Signature _____

Relationship to Patient _____

Date _____

**FOR OFFICE STAFF USE ONLY:**

_____ Patient refused to sign.
ATHENS DENTAL SERVICES employee signature _____