Today's Date: _______________

Patient Information:

First Name:_____________________ Last Name:____________________

Date of Birth:___________ Social Security Number:_______________________

Responsible Party Information:

First Name:_____________________ Last Name:____________________ Employer:_____________

Date of Birth:___________ Social Security Number:_______________________

Address:_______________________ City:___________ State:_________ Zip Code:___________

Home Phone:_______________ Mobile Phone:_________________ Work Phone:_______________

Insurance Information:

Company Name:_________________________________ Member ID #:_________________________

Policy Holder Name:______________________________ Policy Holder Date of Birth:______________

Policy Holder Social Security Number:________________ Employer:____________________________

*If you have secondary insurance please notify the front desk

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes

Signature____ Date:_____________

Acknowledgement of Receipt of Privacy Practices

I,_________________________ understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPPA). I understand that by signing this consent;

I authorize you to use and disclose my protected health information to carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), obtaining payment from third party payers (i.e. my insurance company) and for the day to day healthcare operation of your practice.

I have also been informed of and given the right to review and secure a copy of your notice of privacy practices which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions, however, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Name:_________________________ Signature_____________________________ Date__________

Relationship to the patient if under 18 or unable to sign ____

Acknowledgement of Receipt of Financial Responsibility

I certify that I, and/or my dependent have insurance coverage with ____________________ (name of insurance company), and assign directly to Rubicon Dental Associates all insurance benefits (if any). I understand that I am financially responsible for all charges whether or not they are paid by insurance.

I understand that if I do not have an insurance carrier that I am responsible for the balance on the account at the time the charges are incurred. I also understand that if I do not pay my balance that finance charges will be added onto my balance after 30 days.

Print Name:_________________________ Signature_____________________________ Date__________