ORAZIO DENTAL

Name: _____

Date: _____

# New Patient Registration / HIPAA Acknowledgement & Consent

**PATIENT INFORMATION**

Patient's FULL name: _____ Date of Birth: _____

Name you prefer to be called: _____ Gender:_____ Gender Pronouns: _____

Street Address: _____ City/State/Zip: _____

Primary Phone Number: _____ ◯ Cell ◯ Home ◯ Work

Alternate Phone Number: _____ ◯ Cell ◯ Home ◯ Work

Email: _____

Patient Employer, if applicable: _____ Patient Occupation: _____

Whom may we thank for referring you? _____

Name and Phone Number of most recent dental provider: _____

Date of last dental exam? _____ dental x-rays? _____ dental cleaning? _____

**PRIMARY DENTAL INSURANCE (If no insurance, skip to ACCOUNT section)**

Your relationship to the Insured: ◯ Self ◯ Spouse/Partner ◯ Dependent DOB of Insured: _____

Full Name of Insured if NOT self: Insured's Employer:

Group Number: ID or SSN for **Patient**: Ins Company Phone Number: _____

Dental Insurance Company Name & Address:

**SECONDARY DENTAL INSURANCE (If no secondary insurance, skip to ACCOUNT section)**

Your relationship to the Insured: ◯ Self ◯ Spouse/Partner ◯ Dependent DOB of Insured: _____

Full Name of Insured if NOT self: Insured's Employer:

Group Number: ID or SSN for **Patient**: Ins Company Phone Number: _____

Dental Insurance Company Name & Address:

**ACCOUNT**

Your relationship to the individual responsible for this account: ◯ Self ◯ Spouse/Partner ◯ Dependent

Name of responsible individual if NOT self: Phone Number: _____

Address of responsible party: City/State/Zip:

Employer of responsible party:

**HIPAA ACKNOWLEDGEMENT & CONSENT TO RELEASE INFORMATION**

The undersigned acknowledges receipt or offer of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

**My signature also serves as a PHI document release/consent should I request treatment or x-rays be sent to other attending doctors/facilities in the future.**

**SIGNATURE:**

Printed name of patient:

NAME and RELATIONSHIP of patient representative/guardian (if applicable):

*Please list NAME and RELATIONSHIP for any other parties who can have access to your health information:*
(This includes step parents, grandparents and anyone you wish to have access)

In signing this HIPAA Acknowledgement & Consent to Release Information Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

**Office Use Only** As Privacy Officer, I attempted to obtain the patient's signature on this Acknowledgement but did not for the following reason (circle one):

It was emergency treatment / I could not communicate with the patient / The patient refused to sign / The patient was unable to sign because:

SIGNATURE OF PRIVACY OFFICER: