



PATIENT INFORMATION

PATIENT'S FULL NAME _____ Nickname _____

DOB _____ Age _____ Sex: M F SS#: _____ Check One: Single Married Widowed Divorced Separated

Address _____ City: _____ State _____ Zip _____

Home Ph# _____ Cell# _____ Work# _____ Email _____

Place of employment _____ Full-time Part-time

School: _____ Full-time Part-time

Referred by _____ General Dentist _____

Orthodontist _____ Primary care physician _____ Friends/ Relatives seen by Dr. Worley _____

RESPONSIBLE PARTY _____ DOB _____ SS# _____ Home Ph#: _____ Cell: _____

Address (if different from above) _____ Relationship to patient _____

EMERGENCY CONTACT _____ Relationship: _____ Home# _____ Cell# _____

DENTAL INSURANCE _____ ID# _____ Group# _____

Phone# _____ Address _____ City _____ State _____ Zip _____

Policyholder's name _____ Relationship to patient _____ DOB _____ SS# _____

Employer _____

MEDICAL INSURANCE _____ ID# _____ Group# _____

Phone# _____ Address _____ City _____ State _____ Zip _____

Policyholder's name _____ Relationship to patient _____ DOB _____ SS# _____

Employer _____

AUTHORIZATION, RELEASE & ACKNOWLEDGEMENT OF PAYMENT I authorize the doctor and other dentists or health-care professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper care. I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment and to use the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature. I authorize **Mountain View Oral Surgery & Dental Implants** to release any information (via mail, email or fax) including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such dental/medical care to third party payors, and other entities and/or health practitioners. I authorize and hereby request my insurance company to pay directly to Mountain View Oral Surgery & Dental Implants any benefits otherwise payable to me. I understand that my insurance carrier(s) may pay less than the actual bill for services. **I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT WITHIN 60 DAYS OF SERVICES RENDERED ON MY BEHALF OR ON BEHALF OF MY DEPENDENTS REGARDLESS OF INSURANCE STATUS.** Finally, the HIPAA Notice of Privacy Practices has been made available to me and/or my dependent & I give consent for this office to discuss my treatment plan and financial responsibilities with the following people:

Signature of Patient/Guardian _____ Date _____

Staff Signature: _____ Date _____