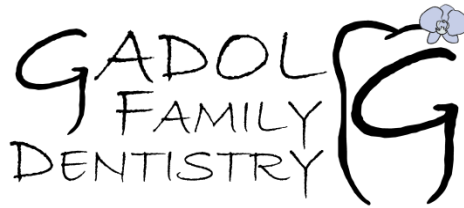


Welcome to Gadol Family Dentistry!



Patient Information:

Last Name: _____ First Name: _____ MI: ____ Sex: M F
Preferred Name: _____ Birth Date: _____ SSN: _____
Marital Status: Single Married Divorced Widowed Other: _____
Address: _____
City: _____ State: _____ Zip Code: _____
If patient is a minor... Name of Responsible Party: _____
Relationship to Patient: Parent Guardian Other: _____

Contact Information:

Home # (____) _____ - _____ Work # (____) _____ - _____ x _____ Cell # (____) _____ - _____
Best way to reach you during the day: Home Work Cell Email Other
Preferred email(s): _____
May we contact you by E-mail for correspondence and appointment confirmation? Yes No

Other:

Emergency Contact: _____ Phone / Email: _____
Primary Physician: _____ Phone: _____
Whom may we thank for referring you? _____

Dental Insurance:

I do not have dental insurance.

Subscriber Information:

Name: _____ Employer: _____
SSN: _____ DOB: _____ Relationship to Patient: _____

Insurance Information: [Please fill out all information below or provide your insurance card]

Company Name: _____ Phone #: _____
Claims Address: _____ Group #: _____

I hereby authorize the provider to release any information required to process insurance claims and authorize assignment of my insurance rights and benefits directly to the provider for services rendered: _____ (Initials)

I certify that the above information is complete and correct to the best of my knowledge.

SIGNATURE _____ DATE _____

Acknowledgment of Receipt of Notice of Privacy Practices

I have read and/or received a copy of the Notice of Privacy Practices for Gadol Family Dentistry.

SIGNATURE _____ DATE _____