MICHIGAN DENTAL SPECIALISTS

Periodontics
Oral Surgery
Dental Implants

DAVID LIPTON DDS, MS JOE HILDEBRAND, DDS

Date

PATIENT INFORMATION

Name_____Nickname_____MI_____SSN #_____/_____/_____

Mailing Address _____ Physical Address _____
Only if mailing address is PO Box

City_____State_____ZIP_____City_____State_____ZIP_____

Marital SINGLE MARRIED

Home Ph ( )_____ Pt. Cell ( )_____Status ☐ ☐ Parent or Spouse's Name _____

Patient's Date of Birth_____/_____/_____ Sex ☐ Male ☐ Female Student? FT ☐ PT ☐ N/A ☐ Guarantor's E-mail Address_____@_____

Employer_____Phone ( )_____Ext____ Occupation _____

Person/Party financially responsible for account: ☐ Self ☐ Parent ☐ Other: Whom? _____ If

Patient is a minor, person minor resides with: Name_____Relationship _____

Social Security #_____Date of Birth_____/_____/_____

Address_____City_____State_____ZIP _____

Your Dentist's name:_____Your Medical Doctor's name: _____

Dentist's phone: _____ Doctor's phone: _____

Person who referred you to us: _____ Pharmacy phone: _____

Emergency Contact:_____ ( )_____ _____
Name Phone Number Relationship

Have any family members been seen in our office? ☐ Yes ☐ No Name: _____

INSURANCE INFORMATION *(If patient has additional insurance information, please see receptionist for another form)*

Primary Insurance

Policy Holder _____
last name first name MI
☐ Male ☐ Female

Relationship to patient: Self ☐ Spouse ☐
Parent ☐ Step-parent ☐ Guardian ☐

SS #_____DOB _____

Address: _____
If different than patient's

Employer Name _____ Employer Phone ( ) _____

Secondary Insurance

Policy Holder _____
last name first name MI
☐ Male ☐ Female

Relationship to patient: Self ☐ Spouse ☐
Parent ☐ Step-parent ☐ Guardian ☐

SS #_____DOB _____

Address: _____
If different than patient's

Employer Name _____ Employer Phone ( ) _____

****

Name of **MEDICAL**
Insurance_____
Insurance Benefits phone # (_____)_____
Group #_____ID # _____

****

Name of **DENTAL**
Insurance_____
Insurance Benefits phone # (_____)_____
Group #_____ID # _____

****

Name of **MEDICAL**
Insurance_____
Insurance Benefits phone # (_____)_____
Group #_____ID # _____

****

Name of **DENTAL**
Insurance_____
Insurance Benefits phone # (_____)_____
Group #_____ID # _____

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PATIENT CONSENT FOR USE, TREATMENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

My signature confirms that I have been informed of my rights to privacy regarding my protected health information and I understand that, under the HIPAA ACT of 1996, I have certain rights to privacy regarding my health information. (Privacy Notice information is available upon request.) I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of oral/medical health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my services

I have been informed of my oral health care provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such Notice of Privacy Practices. I understand that my dental provider has the right to change the notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Print) _____

Patient Signature_____**Date** _____

Parent Name if Minor Child (Print) _____

Parent Signature of Minor Child_____**Date** _____

Dependent family members also covered by this acknowledgement:

_____

I Request the following person(s) to receive information regarding my protected health information.

Name_____**Relationship**_____**Birth Date** _____

Name_____**Relationship**_____**Birth Date** _____