INNOVATIVE DENTISTRY

PATIENT INTAKE FORM

PATIENT INFORMATION

Last Name	First Name		Middle Initial	Social Security Number	
Street Address	City	State	Zip Code	Date of Birth	Age
Primary Phone #	Email Address				

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

PRIMARY INSURANCE

Holder: _____

Insurance Co: _____

Group #: _____

Member id: _____

Phone: _____

SECONDARY INSURANCE (if applicable)

Holder: _____

Insurance Co: _____

Group #: _____

Member id: _____

Phone: _____

EMPLOYER

Name: _____

Address: _____

City, State Zip: _____

Occupation: _____

Phone: _____

SPOUSE/PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Relationship: _____

Phone 1: _____

Phone 2: _____

May we share personal medical information? ☐ Yes ☐ No

EMERGENCY CONTACT

NAME: _____

PHONE: _____

RELATIONSHIP TO PATIENT: _____

ALLERGIES

_____

_____

_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the provider or clinic. I authorize my provider to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of medical care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

_____ _____ _____

Patient / Guardian Signature *(If guardian, write name please)* Date