PATIENT INFORMATION FORM

PIN_____

NAME_____

ADDRESS_____

CITY_____ ST_____ ZIP CODE_____

HOME PHONE_____ CELL PHONE_____

WORK PHONE_____ ext._____

EMAIL ADDRESS_____

****How would you prefer to receive copies of the correspondence that is sent to your dentist?****

*******************EMAIL OR TRADITIONAL MAILING (circle your preference)****************

BIRTHDATE_____

OCCUPATION_____

EMPLOYER_____

GENERAL DENTIST_____ PHONE_____

PHYSICIAN_____ PHONE_____

SPOUSE'S NAME_____ PHONE_____

EMERGENCY CONTACT_____ RELATIONSHIP_____

ADDRESS_____

CITY_____ ST_____ ZIP CODE_____

HOME PHONE_____ WORK PHONE_____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?_____

I understand and agree that regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the financial information form, and completed the information on both sides of this form. I certify that the information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. I also hereby authorize Drs. Horvat and Cohen, PLLC, Dr. Scott G. Cohen and Dr. Christina M. Rostant to use and disclose my entire medical record in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed and dated consent shall be as effective as its original. I release, hold harmless, and agree to indemnify the Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

SIGNATURE_____ DATE_____

PARENT (if minor)_____ DATE_____