first m.i. last F/M

PATIENT'S NAME_____*Date of Birth*_____

____Child ____Unmarried ____Married ____Separated **Soc.Sec.** #_____

ADDRESS_____**HOME #**_____
Street City, State Zip

EMAIL_____ **CELL #**_____

EMPLOYER_____**WORK #**_____

OCCUPATION_____

SPOUSE'S NAME_____Date of Birth_____
Soc.Sec.#_____

SPOUSE'S EMPLOYER_____**WORK #**_____

Previous Dentist_____Referred By_____

Person responsible for Bill, if not Patient

NAME_____Relationship_____
First M.I. Last

Soc.Sec.#_____

ADDRESS_____Home #_____
Street City,State Zip

EMPLOYER_____Work #_____

Occupation_____

Insurance Information

Primary Insurance Co. Patient's relationship to
_____subscriber_____
Address_____ _Policy #_____

Subscriber Name_____Soc. Sec.#_____
Birth Date_____

Secondary Insurance Co. Patient's relationship to
_____subscriber_____
Address_____ Policy #_____

Subscriber Name_____Soc.Sec.#_____
Birth Date_____

The above information is complete and accurate to the best of my knowledge. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing, Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. If patient above is unable to keep a scheduled appointment, 24 hour advanced notice is needed to avoid a possible failed appointment charge. In the event legal action should be come necessary to collect an unpaid balance due for services rendered to me or my family, I/we agree to pay collections fees, reasonable attorney's fees, filing fees and any other such costs as the Court determines proper. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collections thereof. (A copy of this agreement is as valid as the original.)

Notice: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of the agreement at the time you sign. Keep it to protect your legal rights.

Agreement: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification.

_____

PATIENT OR GUARANTOR'S SIGNATURE **TODAY'S DATE**

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Kim A Anardi, D.D.S. P.C
1320 8th Street N.E. #101
Auburn, WA 98002

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ☐ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ☐ Obtain payment from third-party payers for my health care services
- ☐ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental 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 and receive a copy of 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: ______________________________ Date: ______________________

Signature: ________________________________

Relationship to Patient: ______________________

Dependent family members also covered by this acknowledgement:

____

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For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other