New Patient Information

Date_____

Name_____ Male_____Female___
Last First Middle

Address_____City_____

State_____Zip_____ Home Phone#_____

Business phone #_____Cell phone #_____ Preferred contact # h( ) b( ) c( )

Social Security_____ Date of Birth____/_____/_____Occupation_____
Mo day year

Email address_____Referred by_____

Marital Status_____Spouses name if applicaible_____

Contact in case of emergency_____ Responsible Party_____

Relationship_____Emergency contact phone #_____

Chief Dental Complaint _____

Please bring your dental insurance card to the appt. This is often different from medical.

Dental Insurance Information: Primary cardholder's name_____

Cardholder's employer_____Cardholder's SS# or subscriber ID_____

Cardholder's Date of Birth_____/_____/_____ Dental Ins. Co_____ Group #_____
Mo day year

Notice of Privacy Practices: Please read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of how we use and protect your health and personal information. We encourage you to read it carefully before signing. We reserve the right to change our policy. You may obtain a copy of our Notice of Privacy Practices at anytime by contacting our office.
Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice.
Signature: I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that by signing I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I have been offered a copy of our Notice of Privacy Practices.
Signature_____

Financial Policy: I understand that I am fully responsible for the balance of my account due at the time services are preformed.
Signature_____

Consent for treatment: I give Eric Schorn DDS and/or Amy Schorn DDS permission to perform procedures including but not limited to: giving anesthesia and medications, making radiographs and photographs, cleaning and exams, restoring and removing teeth, root canals and any other procedures necessary for my dental therapy.
Signature_____