Welcome to GERMANTOWN DENTAL

2627 Germantown Ave. Philadelphia Pa. 19133

Patient Information

Today's Date ____ Male ______ Female ______ Marital Status ____________

Name ____ Date of Birth ____________________________________

Address ____ Apt. No. __________

City ____ State ______________________________ Zip Code _____________

Home Phone No. ____ Work Phone No. _____________________________

Cell Phone/Pager ____________________________________ **Email Address**_____________________________________
(if you want to be contacted this way)

Social Security No. _______________________________________

Person to contact in case of emergency ____

Responsible Party

Name ____ Relationship to Patient________________________

Address ____ City, State, Zip Code _____________________________
(if different from above)

Home Phone No. ____ Work Phone No. _______________________________

Social Security No. ____ Driver's License No. ______________________________

Insurance Information

Employee Name _____________________Employer Name _______________________Insurance Co. ____________________

Group No. _________________ Employee Date of Birth _________________________Employee SSN:____________________

General dental treatment consent, HIPAA - PHI consent and financial agreement

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) ____________________________'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetic, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that: Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The Practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that I shall be responsible for any and all expenses incurred at this office, and I understand that payment is due at the time of service unless other arrangements have been made, regardless if I have insurance. In the event payments are not received by agreed upon date, I understand that a 1.5% late charge and any expenses such as attorney fees if engaged for the purpose of collection may be added to my account.

Patient or Responsible Party ____ Date ____________________________