align braces & kids' dental

A B C I

Date:

NEW PATIENT QUESTIONNAIRE

Patient's Name: _____ Gender: M / F
Last First Middle

Address: _____
Street City State Zip

Birthdate: _____/_____/_____ Social Security #: _____/_____/_____ Cell Phone: _____

How would you like to receive appointment reminders? Email: _____ Text Message: _____
Email address Cell Phone #

How did you hear about us / who referred you? _____

RESPONSIBLE PARTY INFORMATION

Primary Responsibility Party: _____ SS # _____
Last First Middle

Address (if different): _____
Street City State Zip

Cell Phone: _____ Home Phone: _____ Email: _____

Birthdate: _____/_____/_____ Relationship to Patient: _____ Spouse's Name: _____

Employer: _____ Occupation: _____ Yrs Employed: _____

Secondary Responsibility Party: _____ SS # _____
Last First Middle

Address (if different): _____
Street City State Zip

Cell Phone: _____ Home Phone: _____ Email: _____

Birthdate: _____/_____/_____ Relationship to Patient: _____ Spouse's Name: _____

Employer: _____ Occupation: _____ Yrs Employed: _____

NOTICE of PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payments from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time to obtain a current copy of the *Notice of Privacy Practices*.
I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand this office is not required to agree to my requested restrictions, but if agreed upon then is bound by such restrictions.

AUTHORIZATION and RELEASE:

I have read, understood and answered the above questions and statements to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in the future. I authorize the dental staff to perform the necessary dental services.

Patient Signature (Parent if minor): _____ **Date:** _____