# Welcome!

**Today's Date: _____**

**Patient Information**

Name: _____ I prefer to be called: _____

Address: _____ City: _____ Zip Code: _____

Phone # _____ Work # _____ Other # _____

Social Security # _____ Date of Birth: _____

I am: a minor • Single • Married • Other The best time to contact me is: Morning • Afternoon

Email Address: _____

☐ Please check this box if you would like to receive special offers and information via e-mail

Whom may we thank for referring you? _____

Person to call in case of emergency _____

Phone # _____Relationship to Patient _____

**Responsible Party**

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ Zip Code: _____

Phone # _____ Employer: _____

Employer Address: _____ Employer Phone # _____

**Insurance Information**

Name of Insured: _____ Date of Birth: _____

Name of Insurance: _____ Insurance phone # _____

SSN or ID # _____ Group # _____

Insurance Address: _____ City: _____ State: _____ Zip Code _____

**Do you have additional Insurance? If so, please complete the following…**

Name of Insured: _____ Date of Birth: _____

Name of Insurance: _____ Insurance phone # _____

SSN or ID # _____ Group # _____

Insurance Address: _____ City: _____ State: _____ Zip Code _____

4M DENTAL IMPLANT CENTER®

# Consent for Use and Disclosure of Health Information (HIPAA)

**Section 1: Patient giving Consent**

Name of Patient _____

**Section 2: PATIENT PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice is available at your request in our office. We encourage you to request a copy and read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy practices. If we change our privacy practices, we will issue a revised Noticed of Privacy which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Fatima Zuniga, Office Manager

Phone (714) 974-5223

Fax (714) 974-5223

E-mail: ahsmile@4mdentalimplants.com

Right to revoke: You will have the right to revoke this consent at any time by providing our office with a written notice of your revocation submitted to the contact person listed above. Please understand that the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Consent: I, the patient has had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand by signing this consent form, I am giving my consent to use and disclose of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____