Confidential Patient Information

Alfred A. Thresher D.D.S.

*Patient Name*_____ *Social Security Number*_____

Patient Birthday _____ *Email address* _____

Home Address _____

Home Phone _____ *Cellular Phone* _____ *Work/Alt. Phone* _____

How did you hear about our practice? _____ *What School do you attend?* _____

Responsible Party Information

Name _____ *Marital Status* _____ *Birthday* _____

Social Security _____ *Employer* _____ *Occupation* _____

Home Phone _____ *Cell Phone* _____ *Email* _____

Home Address _____

Length at this address _____ *Relationship to Patient* _____

Spouse's Name _____ *Employer* _____ *Occupation* _____

Birthday _____ *Social Security* _____

Home Address if different than patient _____

Insurance Information

Policy Holder's Name _____ *Social Security Number* _____

Policy Holder's Employer _____ *Occupation* _____

Insurance Company Name _____ *Insurance Phone* _____

Group Number _____ *ID Number* _____

Insurance Company Address _____

Do you have Dual Coverage? □*Yes* □*No* *Name of Secondary Insurance*_____

Emergency Contact Information

Name of nearest relative NOT living with you _____ *Relationship to patient* _____

Complete Address _____ *Emergency Contact Phone* _____

Authorization and Release *(please initial)*

- _____*In accordance with* ***HIPAA*** *regulations, I hereby give my permission for the office of Dr. Alfred Thresher to use patient records and information for diagnosis, treatment planning, promotion, educational and insurance purposes.*
- _____*I authorize the orthodontist to release any information including the diagnosis and records for treatment rendered to me or my child if necessary for insurance purposes. I also authorize direct payment of insurance benefits to the dentist for services rendered when indicated.*
- _____*I understand that where appropriate, credit bureau reports may be obtained.*

Signature (Parent's signature if minor) _____ ***Date*** _____