the the first open many despectables for		nformation			
Patient Name:			201 p. 271 202 202 202		
Last	First		Vise following is facility to a nata National		
u iviale u Female		ied □ Single □ Child □ W			
Social Security #:		Birth Date:			
Phone (Home):	(Work):	Ext: Pager of	or Cell #		
Address: Street					
Sireet			Apartment #		
City		State	Zip Code		
Employer Name:					
	A CONTRACTOR AND A CONT				
Spouse or Parent Name:	AND AND ASSESSED.				
A CONTRACTOR OF THE PROPERTY OF THE PARTY OF	Health I	nformation			
Reason for this visit:		count factors and a			
	the following? Please cho	aak thaas that anni-	Santian Transit 1		
		□ Are you Pregnant	☐ Medications you are		
☐ Allergies	☐ Hay Fever	Due Date:	taking:		
Allergic reaction to local	☐ Head Injuries	☐ Radiation Treatment	Carring.		
anesthetics	☐ Heart Disease	☐ Respiratory Problems			
3 Anemia	☐ Heart Murmur	☐ Rheumatic Fever			
☐ Arthritis	☐ Hepatitis	☐ Rheumatism	92.0002		
Artificial Joints	☐ High Blood Pressure	☐ Sinus Problems	188 ADDA		
☐ Asthma	☐ Jaundice	☐ Stomach Problems			
☐ Blood Disease	☐ Kidney Disease	☐ Stroke			
☐ Cancer	☐ Liver Disease	☐ Tuberculosis			
☐ Codeine Allergy	☐ Mitral Valve Prolapse	☐ Tumors			
Diabetes	☐ Mental Disorders	□ Ulcers	the war increment		
☐ Dizziness		☐ Venereal Disease	PAGE TO SERVICE STATE OF THE PAGE TO SERVICE		
☐ Epilepsy	□ Nervous Disorders	☐ OTHER ALLERGIES	alaG dhill abauani		
☐ Excessive Bleeding	□ Pacemaker	2 OTTER ALLERGIES			
☐ Fainting	☐ Penicillin Allergy	The second secon			
□ Glaucoma					
Have you ever had any co	omplications following dental	treatment? Yes No			
If yes, please explain:	99702 data 1	remail User D Spare	i girtansilisien affastfoffi		
Have you been admitted t If yes, please explain:	o a hospital or needed emer	gency care during the past tw	o years? □ Yes □ No		
Are you now under the ca	re of a physician?	□ No			
If yes please explain.		man and a second section of the settless	To early or managed they to available to the		
ii yes, piease explain	Phone:				
	and the states to a M., thus cell lawly of their applicate.	Ph	0110.		
Name of Physician:		arification? □ Yes □ No	Clara de la partir de la la contra en la con		
 Name of Physician: Do you have any health professional of the least of my knowledge 	roblems that need further cla		are true and correct. If Le		
 Name of Physician: Do you have any health point of yes, please explain: To the best of my knowledge have any change in my hear 	ge, all of the preceding answ lth, I will inform the doctors a	arification? ☐ Yes ☐ No	are true and correct. If I e ut fail.		
Name of Physician: Do you have any health property of the best of my knowledge have any change in my health parent or g	roblems that need further cla ge, all of the preceding answ lth, I will inform the doctors a uardian	ers and information provided at the next appointment witho	are true and correct. If I e ut fail. ate:		
Name of Physician: Do you have any health property of the best of my knowledge have any change in my health parent or g	roblems that need further cla ge, all of the preceding answ lth, I will inform the doctors a uardian	ers and information provided at the next appointment witho	are true and correct. If I e ut fail. ate:		
Name of Physician: Do you have any health pure of yes, please explain: To the best of my knowledge have any change in my heather the signature of patient, parent or gray. Whom may we thank for re	ge, all of the preceding answelth, I will inform the doctors and uardian Referral ferring you to our practice?	arification? □ Yes □ No ers and information provided at the next appointment witho	are true and correct. If I e ut fail.		

The following is for. In the patient's spo	Douse or Responsible the person responsible	ole Party Inform	nation	Parish Indian
Name: Male Female			590.1	A THE LOCATION OF THE LOCATION
Social Security #:		ied Single C	hild Li Other _	HE WITH THE THE THE WORLD
Phone (Home):	(\M\0\r\).	Birth Date:		
Phone (Home):Address:	(VVOFK):	Ext:	Pager or Cell #	
Street				Apartment #
City			A. The state of th	
		State		Zip Code
The following is for: the patient	Employment the person responsible	Information		
Employer Name:				
Address:		Occupation:		
Street		City	State	Zip Code
Primary	Dental Insurance	e Information		
Name of Insured:	ufeça dani riparti (parta	secel? Spokati	Is insured a pa	tient? ☐ Yes ☐ N
Insured's Birth Date:	First ID #:	MI	Group #:	319/8
Insured's Address:	GAIS BUL		Group #	
Street		City	State	Zip Code
Insured's Employer Name:		1,200,180,150,6	1.7	estate and the
Address:	ALCOHOLD TO THE	City	State	
Patient's relationship to insure	d: Self Spouse C	Child Other	State	Zip Code
Insurance Plan Name and Addres				
	alself modern til	0.306/176		
Secondary	etomul E	Account to the second of the second		
Name of Insured:	First	aus/mose/Tilagra	Is insured a par	tient? ☐ Yes ☐ N
Insured's Birth Date:	ID #:	and Disorders	Group #:	
nsured's Address:				
nsured's Employer Name:		City	State	Zip Code
Address:				
Patient's relationship to insure	d. I Self I Spause I	City	State	Zip Code
nsurance Plan Name and Addres			A CONTRACTOR OF THE CONTRACTOR	<u> </u>
risdiance i lan ivanie and Addres	S. Harman S. A. L. Carlotte	+ trabular to tollow		c traff in Ay Buyesi e
			195628	
	Consent for	Sorvices		B. 0.20 B. 30 B. 1
s a condition of your treatment by this office, financial and financial responsibility on the nod of contraction	Consent for		imbursement from the pati	ents for the costs incurred in th
	arrangements must be made in advance. ant must be determined before treatment.	The practice depends upon re		
If emergency dental services, or any dental services per latients who carry dental insurance understand that all	arrangements must be made in advance, ant must be determined before treatment, arformed without previous financial arrang	The practice depends upon re	sh at the time services are	performed.
all emergency dental services, or any dental services per l'attents who carry dental insurance understand that all ervices. This office will help prepare the patients insura lowever, this dental office cannot render services on the	arrangements must be made in advance, ent must be determined before treatment, entrommed without previous financial arrang dental services furnished are charged diri- ance forms or assist in making collections e assumption that our charges will be pak	The practice depends upon re- perments, must be paid for in ca- actly to the patient and that he from insurance companies and d by an insurance company.	sh at the time services are or she is personally respor d will credit any such collec	performed. sible for payment of all dental tions to the patient's account.
all emergency dental services, or any dental services per l'attents who carry dental insurance understand that all ervices. This office will help prepare the patients insura lowever, this dental office cannot render services on the	arrangements must be made in advance, ent must be determined before treatment, entrommed without previous financial arrang dental services furnished are charged diri- ance forms or assist in making collections e assumption that our charges will be pak	The practice depends upon re- perments, must be paid for in ca- actly to the patient and that he from insurance companies and d by an insurance company.	sh at the time services are or she is personally respor d will credit any such collec	performed. sible for payment of all dental tions to the patient's account.
all emergency dental services, or any dental services per leatients who carry dental insurance understand that all ervices. This office will help prepare the patients insuration to the control of the c	arrangements must be made in advance, and must be determined before treatment. arformed without previous financial arrange dental services furnished are charged dire ance forms or assist in making collections as assumption that our charges will be pake in the unpaid balance will be charged on a	The practice depends upon re- perments, must be paid for in ca- actly to the patient and that he from insurance companies and d by an insurance company.	sh at the time services are or she is personally respor d will credit any such collec , unless previously written	performed. sible for payment of all dental tions to the patient's account.
all emergency dental services, or any dental services per eatients who carry dental insurance understand that all of ervices. This office will help prepare the patients insurance developer, this dental office cannot render services on the service charge of 11/2% per month (18% per annum) of allisfied. Understand that the fee estimate listed for this dental can consideration for the professional services rendered to	arrangements must be made in advance, on must be determined before treatment, arformed without previous financial arrange dental services furnished are charged dirance forms or assist in making collections assumption that our charges will be paid in the unpaid balance will be charged on a are can only be extended for a period of s	The practice depends upon re- perments, must be paid for in ca- ectly to the patient and that he from insurance companies and d by an insurance company. all accounts exceeding 60 days six months from the date of the	sh at the time services are or she is personally respor d will credit any such collect , unless previously written patient examination.	performed. sible for payment of all dental tions to the patient's account. financial arrangements are
all emergency dental services, or any dental services per latients who carry dental insurance understand that all envices. This office will help prepare the patients insuration to the patients insuration of the patients of the control of the patients of the services on the service charge of 1½% per month (18% per annum) of alished. Understand that the fee estimate listed for this dental of consideration for the professional services rendered to the time said services are rendered, or within five (5), by me, in writing, within the time for payment the perfective part of the perfective part	arrangements must be made in advance, ent must be determined before treatment, enformed without previous financial arrang dental services furnished are charged din ance forms or assist in making collections as assumption that our charges will be pake in the unpaid balance will be charged on a are can only be extended for a period of so to me, or at my request, by the Doctor, I at days of billing if credit shall be extended.	The practice depends upon re- perments, must be paid for in ca- actly to the patient and that he from insurance companies an d by an insurance company. all accounts exceeding 60 days exix months from the date of the gree to pay therefore the reason I further agree that the reason	sh at the time services are or she is personally respor d will credit any such collect t, unless previously written patient examination.	performed. sible for payment of all dental thous to the patient's account. financial arrangements are s to said Doctor, or his assigne
all emergency dental services, or any dental services per latients who carry dental insurance understand that all envices. This office will help prepare the patients insuration to the patients insuration of the patients of the service charge of 1½% per month (18% per annum) of alisfied. Understand that the fee estimate listed for this dental can consideration for the professional services rendered to the time said services are rendered, or within five (5), by me, in writing, within the time for payment thereof on dillon and I further agree to pay all costs and reason.	arrangements must be made in advance, and must be determined before treatment, or formed without previous financial arranged ental services furnished are charged directions or assist in making collections as assumption that our charges will be paken the unpaid balance will be charged on a care can only be extended for a period of some, or at my request, by the Doctor, I addays of billing if credit shall be extended. I further agree that a waiver of any breastable attorney feas if suit be instituted here	The practice depends upon re- perments, must be paid for in ca- ectly to the patient and that he from insurance companies and d by an insurance company, all accounts exceeding 60 days is months from the date of the gree to pay therefore the reason of of any time or condition her sunder.	sh at the time services are or she is personally respor d will credit any such collect t, unless previously written patient examination.	performed. sible for payment of all dental thous to the patient's account. financial arrangements are s to said Doctor, or his assigne
all emergency dental services, or any dental services per equilibrium of the patients who carry dental insurance understand that all insurance understand that all insurances. This office will help prepare the patients insurance of the patients insurance of the service charge of 1½% per month (18% per annum) of alisfied. Understand that the fee estimate listed for this dental can consideration for the professional services rendered to the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) on the professional services are rendered, or within five (5) on the professional services are rendered, or within five (5) on the professional services are rendered, or within five (5) on the professional services are rendered, or within five (5) on the professional services are rendered, or within five (5) on the professional services are rendered, or within five (5) on the professional services are rendered, or within five (5) on the professional services are rendered, or within five (5) on the professional services are rendered, or within five (5) on the professional services are rendered, or within five (5) on the professional services are rendered, or within five (5) on the professional services are rendered, or within five (5) on the professional services are rendered, or within five (5) on the professional services are rendered, or within five (5) on the professional services are rendered, or within five (5) on the professional services are rendered at the professio	arrangements must be made in advance, on must be determined before treatment, or formed without previous financial arrangemental services furnished are charged directions or assist in making collections as assumption that our charges will be paken the unpaid balance will be charged on a care can only be extended for a period of some, or at my request, by the Doctor, I are tays of billing if credit shall be extended. I further agree that a waiver of any breaus to the comment of the present of the comment of the present of the present of the comment of the present of the comment of the present of the	The practice depends upon re- perments, must be paid for in ca- ectly to the patient and that he from insurance companies and d by an insurance company. all accounts exceeding 60 days fix months from the date of the gree to pay therefore the reason the of any time or condition here eunder. matters related to this form.	sh at the time services are or she is personally respor d will credit any such collect t, unless previously written patient examination.	performed. sible for payment of all dental thous to the patient's account. financial arrangements are s to said Doctor, or his assigne
all emergency dental services, or any dental services per patients who carry dental insurance understand that all insurances. This office will help prepare the patients insurance to the patients insurance to the patients of the services. This dental office cannot render services on the service charge of 1½% per month (18% per annum) of alished. Understand that the fee estimate listed for this dental can consideration for the professional services rendered to the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered.	arrangements must be made in advance, sont must be determined before treatment, arformed without previous financial arrangedental services furnished are charged directions or assist in making collections as assumption that our charges will be paken the unpaid balance will be charged on a care can only be extended for a period of some, or at my request, by the Doctor, I are days of billing if credit shall be extended. I further agree that a waiver of any breaus able attorney fees if suit be instituted here one me at home or at my work to discussent and payment and agree to	The practice depends upon re- gements, must be paid for in ca- gettly to the patient and that he from insurance companies and d by an insurance company. all accounts exceeding 60 days fix months from the date of the gree to pay therefore the reason the of any time or condition here bender. matters related to this form. their content.	sh at the time services are or she is personally respond will credit any such collect, unless previously written patient examination. In the patient examination and the value of said services able value of said services aunder shall not constitute	performed. sible for payment of all dental tions to the patient's account. financial arrangements are s to said Doctor, or his assigne shall be as billed unless object a waiver of any further term or
atients who carry dental services, or any dental services per eatients who carry dental insurance understand that all dervices. This office will help prepare the patients insurance towever, this dental office cannot render services on the aservice charge of 11/4% per month (18% per annum) of atisfied. Understand that the fee estimate listed for this dental can consideration for the professional services rendered to the time said services are rendered, or within five (5) of by me, in writing, within the time for payment thereof, and it further agree to pay all costs and reasoning rant my permission to you or your assignee, to telepholia the product of the above conditions of treatments.	arrangements must be made in advance, sont must be determined before treatment, arformed without previous financial arrangedental services furnished are charged directions or assist in making collections as assumption that our charges will be paken the unpaid balance will be charged on a care can only be extended for a period of some, or at my request, by the Doctor, I are days of billing if credit shall be extended. I further agree that a waiver of any breaus able attorney fees if suit be instituted here one me at home or at my work to discussent and payment and agree to	The practice depends upon re- perments, must be paid for in ca- ectly to the patient and that he from insurance companies and d by an insurance company. all accounts exceeding 60 days fix months from the date of the gree to pay therefore the reason the of any time or condition here eunder. matters related to this form.	sh at the time services are or she is personally respond will credit any such collect, unless previously written patient examination. In the patient examination and the value of said services able value of said services aunder shall not constitute	performed. sible for payment of all dental tions to the patient's account. financial arrangements are s to said Doctor, or his assigne shall be as billed unless object a waiver of any further term or
As a condition of your treatment by this office, financial a care and financial responsibility on the part of each patie and financial responsibility on the part of each patie all emergency dental services, or any dental services per patients who carry dental insurance understand that all elevices. This office will help prepare the patients insurance on the services denarge of 11/2% per month (18% per annum) of allished. Understand that the fee estimate listed for this dental can consideration for the professional services rendered to the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered. Or within five (5) of the time said services are rendered, or within five (5) of the time said services are rendered. Or within five (5) of the time said services are rendered to the time said services are rendered. Or within five (5) of the time said services are rendered to the time said services are rendered. Or within five (5) of the time said services are rendered to the time said services are rendered to the time said services are rendered.	arrangements must be made in advance, and must be determined before treatment, and must be determined before treatment. If offermed without previous financial arrange dental services furnished are charged din ance forms or assist in making collections are assumption that our charges will be paken the unpaid balance will be charged on a sacre can only be extended for a period of some, or at my request, by the Doctor, I adays of billing if credit shall be extended. I further agree that a waiver of any breauble attorney fees if suit be instituted here one me at home or at my work to discuss ent and payment and agree to	The practice depends upon re- gements, must be paid for in ca- gettly to the patient and that he from insurance companies and d by an insurance company. all accounts exceeding 60 days fix months from the date of the gree to pay therefore the reason the of any time or condition here bender. matters related to this form. their content.	sh at the time services are or she is personally respond will credit any such collect, unless previously written patient examination, anable value of said services able value of said services aunder shall not constitute onship to Patient:	performed. sible for payment of all dental titons to the patient's account. financial arrangements are s to said Doctor, or his assigne shall be as billed unless object a waiver of any further term or

CONSENT

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment for insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restrictions.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature:		
	Date	
Patient, parent or legal guardian		
If signed by patient representative, state relationship to patient		