4 Dental Insurance Info

Please present your insurance card so we can keep a copy on file.

Primary Insurance

Name of insured _____

Relationship to patient _____

Insured Birthdate _____

Social Sec # _____

Employer _____

Insurance company _____

ID # _____

Group # _____

Secondary Insurance

Name of Insured _____

Relationship to patient _____

Insured Birthdate _____

Social Sec # _____

Employer _____

Insurance Company _____

ID # _____

Group # _____

5 Authorization and Release

To the best of my knowledge, the information reported on this form is complete and correct. I understand it is my responsibility to notify the office if any changes in this information occurs.

I assign directly to Hinton Family Dental all insurance benefits, if any, otherwise payable to me for services rendered on me &/or my dependents. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Hinton Family Dental may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits. I also authorize the release of my protected health information to other health care practitioners as necessary to carry out the optimal treatment, payment activities and healthcare operations for my dental needs.

I grant my permission to Hinton Family Dental to contact me at home, on my cellphone, or at my workplace to discuss matters related to my treatment or account. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

Signature_____ Date_____

Print Name_____ Relationship to Patient_____

6 HIPAA Acknowledgement

I acknowledge that I have reviewed a copy of Hinton Family Dental's HIPAA Notice of Privacy Practices. By signing this form I consent to the policies as described in this notice.

Signature_____ Date_____ Relationship to Patient_____

You may obtain a copy of our notice from our office staff or visit www.hintonfamilydental.com under "New Patient Forms"

The highest compliment our patients can give, is the referral of their friends and family.
Thank you for your trust!

Welcome!

Thank you for selecting Hinton Family Dental! To help us meet all your dental healthcare needs effectively and efficiently, we ask that you fill out this form completely in ink.
If you have any questions or need assistance, please ask us – we will be happy to help!

Date_____

1 Personal Information

Please present photo ID with completed paperwork.

Name_____ Preferred Name _____
Birth date_____ SSN _____ Driver's license # _____
Email Address_____
Gender ☐ Male ☐ Female / ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Divorced ☐ Partnered

Address_____

City_____ State _____ Zip _____

Employer/School _____Occupation_____

Are any members of your household current patients with us? If yes, please tell us their name _____

Whom may we thank for referring you? _____

2 Telephone

Home phone _____Work phone_____ Ext_____

Cell phone _____

Where do you prefer to receive calls? (Mark all that apply) ☐ Home ☐ Work ☐ Cell

When available, would you like to be contacted through text messaging or email if we cannot reach you by phone? Y / N

When is the best time to reach you? Time _____ Days of the week _____

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone number _____

3 Responsible Party

Who is responsible for this account? _____ Relationship to patient_____

Birthdate _____ SSN _____ Driver's license #_____

Employer_____

Home phone _____ Work phone _____ Cell _____

Currently a patient in our office? _____

Payment is due in full at time of service unless prior arrangements have been approved.

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