Patient Information (Please Print)

Name: _____
First Last Middle Preferred

Birth Date:_____/_____/_____ Email:_____

Cell:_____ Home:_____ Work:_____

Address:_____ City:_____ State:____ ZIP:_____

Social Security:_____ Marital Status:_____ Gender:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Insurance Information (Please Print)

Name of Insurance:_____ Name of Subscriber:_____

ID Number:_____ Subscriber Birth Date:_____/_____/_____ Subscriber Social:_____

Subscriber Employer:_____

Insurance Authorization Statement

Dr. McConnell is not responsible for how your insurance company handles its' claims or for what benefits guarantee what your insurance company will pay. We expect your estimated co-payment at the time of service. Understand that your dental insurance carrier may pay less than the actual billed services. You are responsible for payment of all services rendered to you or on behalf of your dependents. **If payment is not received within 90 days of service, understand that you could be turned over to a collection agency. Understand that you will be held responsible for all collection agency fees, plus the original debt owed.**

HIPPA Omnibus Rule

Patient acknowledgement of receipt of notice of privacy practices and consent/limited authorization & release form.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this health care facility. A copy of this signed, dated document shall be as effective as the original. **My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctor/facility in the future.**

Signature:_____ Date:_____

Relationship to patient:_____