Carolina Aesthetic Dentistry

Patient Information

Name _____

Last *First* *Middle* *Title (Dr., Mr., Mrs., Sr., Jr., etc.)* *Name You Wish to be Called*

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security No. _____ Date of Birth _____ Age _____ Sex ❑ Male ❑ Female

❑ Minor ❑ Single ❑ Married ❑ Widowed ❑ Seperated ❑ Divorced ❑ Other_____

Employer _____ Occupation _____

Employer's Address _____

City _____ State _____ Zip Code _____

Appointment Preferences ❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday Time of Day _____

Reminder Preferrences ❑ Phone # for Reminder Calls _____ ❑ Email _____

If you are interested in receiving email reminders or viewing your account online please provide an email address above.

Person to Contact in Case of an Emergency _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Cell Phone _____

Spouse's Name _____ Date of Birth _____ Social Security No. _____

Employer _____ Work Phone _____ Cell Phone _____

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Health Information Privacy Policies and Procedures

American Dental Associates HIPPA Privacy For Dentists

I understand, under the Health Insurance and Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I am aware this information will be used to:

- Plan, direct, and complete my treatment and follow-up among multiple healthcare providers who may be involved in treatment directly and indirectly.
- Obtain payment from third-party payers for healthcare services.
- Perform normal healthcare operations such as quality assessment and physician certifications.

I have been informed of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time and I may contact this organization at the above address to obtain a current copy of the *Notice of Privacy Practices*.

I realize I may request in writing for this organization to restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I am also aware you are not required to agree to my requested restrictions; however, if you agree you are bound to abide by such restrictions.

Signature _____ Date _____ Relationship to Patient: _____

5641 Poplar Tent Road ● Suite 203 ● Concord, North Carolina 28027
Phone: 704-793-4211 ● Email: keshmiridds@carolina.rr.com ● Fax: 704-793-4210