

Kingston Dental Care Patient Information

Patient Name (print): _____

Address: _____ City: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Age: _____

Birthdate: _____ Marital Status: _____ Social Security #: _____

E-mail address: _____

Employer: _____ Occupation: _____ Dental Insurance: _____

How did you hear about us? **(Please be specific)** _____

Emergency Contact Name: _____ Phone #: _____

Responsible Parent for Minor Patient: _____

Acknowledgement of Receipt, Notice of Privacy Policies

I have received a copy of **Kingston Dental Care's** Notice of Privacy Policies.

Signature: _____ Date: _____

Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

Signature: _____ Date: _____

OFFICE USE ONLY

On _____, Acknowledgement of Receipt of Notice of Privacy Policies Form was delivered. The form was not signed due to:

- Communication barriers which prevented acknowledgement
- An emergency which prevented acknowledgement
- A refusal to sign
- Other _____