## Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

## Insurance Information

**Primary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

**Secondary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

## Consent for Services

I hereby authorize Meydenbauer Dental to take radiographs, study models or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's needs. I also authorize Meydenbauer Dental to perform necessary treatment, medication and therapy, as indicated, and further authorize and consent that Meydenbauer Dental choose and employ such assistance as he/she deems fit. I also understand there may be certain risks associated with dental treatment.

I understand that responsibility for payment of dental services provided in this office for myself or dependents is mine, due and payable at the time services are rendered. I further understand that a 1 ½ % finance charge (18%) annually will be added to any balance over 90 days.

I understand a 48-hour cancellation notice is required if I am unable to keep an appointment. I understand there may be a charge for late cancellation.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible part

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

**Meydenbauer Dental**
**13033 Bel-Red Road; Suite 220**
**Bellevue, WA 98005**
**425.454.8082**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the **Health Portability & Accountability Act of 1996 (HIPAA)**. I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

**I have been informed of my dental provider's 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 that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date _____

Signature: _____

Relationship to Patient: _____

Dependant family members also covered by this acknowledgement:

_____ _____

_____ _____

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**For Office Use Only**

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

o The patient refused to sign.

o Communication barriers.

o Emergency situation.

o Other.