Patient The highlighted fields are required

First Name	Last Name	Middle Initial
Preferred Name		
Address		Apartment
City	State	Zip Code
Birth date	Soc Sec	Drivers Lic
Student Status Full time [ ] Part time [ ] Not a student [ ]	School Name	
Home Phone	Work Phone	Extension / Cell Phone
Marital Status Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ]		
E-mail	How were you invited/referred to our practice?	

Primary Insurance Subscriber

Name of Subscriber	Subscriber Birth Date	Subscriber Soc Sec
Employer	Ins. Company	
	Address	
	City / State / Zip Code	
	Group Number / Subscriber ID / Phone Number	

HIPPA Acknowledgement

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and 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 or 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 (1205 West Dundee Road, Wheeling, IL 60090) to obtain a current copy of the Notice of Privacy Practices.

I understand that I can 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 or Legal Guardian Signature	Date
Dependent Family members also covered by this acknowledgment:	

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:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other