WELCOME TO SILVA ORTHODONTICS

Patient Information

Today's Date ____________________

Patients Full Name____ **DOB:** __________________________

Sex: M___ F___ AGE: _______ SS# ___________________ **Medicaid ID Number**__________________________

Address____ **Apt #** ____________________

City _________________________________**State**_____________ **Zip Code**___________________

Cell ph__________________________ **Home/Alt Ph**_______________________ **Work Ph** _____________________

Whom may we thank for referring you? ____

Check Appropriate Box: Minor___ Single___ Married___ Separated___ Divorced___ Widowed___

•Parent or Legal guardians information only if patients under the age of 18 years old•

Name____**SS#**____________________**D.O.B**____________________

Relationship to patient__________________________________**phone #**_________________________

Age___________ **Gender M__ F__ Email** ____

Insurance Information

I have: Other Insurance ___ CHP+___ Cash Patient ___ if you have dental insurance through your employer please provide us with the following information. Name of your employer____

Name and type of Dental Insurance_____________________________________ **subscribers S S#**______________________________

Patient consent for treatment

I hereby apply and give permission for diagnosis and/or treatment to Dr. Antonio Silva and Staff for me or the minor child named on this application. Such treatment may include the rending of: Anesthesia, Medications or Prescriptions, Radiographs, send copy of records through email or paper mail to other providers, models, orthodontics (braces), retainers, appliances, impressions, exams/diagnostics, oral and facial pictures.

Patients Full Name(please print)____

Patient (guardian) Signature _______________________________________Today's Date _________________________

HIPPA Notice of Privacy Practices

I, ____, hereby acknowledge that I have reviewed and received a copy of this office's Notice of Privacy Practices explaining:

- How this office will use and disclose my protected health information.
- My Privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.
- I understand that the Notice of Privacy practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy practices upon request.

I also understand that if I have any questions or complaints, I may contact:

____

You may also contact the secretary of the U.S. Department of health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature:____ Date:______/______/_________

Name Please Print____

Relationship to Patient: ____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of ________________________________'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

--Patient refused to sign (date of refusal)

--Communications barriers prohibited obtaining an acknowledgement.

--An emergency situation prevented us from obtaining an acknowledgement

--Other____

Attempt was made by:____ Date:_____/__ ___/_______