DR. KINDER & DR. JACOB FAMILY DENTISTRY ❒ Dr. Kinder ❒ Dr. Jacob

Date: ____________________ New Patient: ____________ Update: ____________

PATIENT INFORMATION MEMO

Family Doctor (First and Last Name)			
Name Last	First	M.I.	
Sex M F	Marital Status (circle one) married single divorced widowed Spouse or Significant other Name Ph#	Patient Birth Date	Age
Address		Social Security Number	
City State	Zip Code	Home Phone Number ( )	
Employer's Name	Email Address	Work Phone Number ( )	Extension
EMERGENCY CONTACT (other than parent or spouse)	Phone	Cellular Number ( )	

PLEASE PROVIDE INSURANCE CARDS TO BE COPIED AT TIME OF VISIT.

INSURANCE COVERAGE Y N	Medicaid Number		
First Insurance	Member's Name	Member's Date of Birth	Relationship to Patient
Member's Social Security Number	Group or Acct. No.	Member's Employer (if different from patient)	
Second Insurance	Member's Name	Member's Date of Birth	Relationship to Patient
Member's Social Security Number	Group or Acct. No.	Member's Employer (if different from patient)	

ACCOMPANYING RESPONSIBLE PARTY (for patients under 18*)
*For children of divorced parents, the parent that brings the child in for treatment will be considered the financially responsible party.

Name Last	First	M.I.	
Relationship to Patient	Date of Birth	Social Security Number	
Address	City	State	Zip Code
Home Phone Number	Employer's Name	Work Phone Number	

HOW WILL YOU BE PAYING FOR SERVICES TODAY? ❒ ***CHECK/CASH*** ❒ ***VISA/MC/DISCOVER***

PLEASE NOTE: THIS OFFICE REQUIRES PAYMENT IN FULL WITHIN (30) DAYS OF SERVICE REGARDLESS OF INSURANCE COVERAGE.

ASSIGNMENT & RELEASE

I hereby voluntarily consent to dental care judged necessary by my dentist. I acknowledge that no guarantees have been made to me as a result of this treatment. I hereby assign Joseph E. Kinder D.D.S., P.C. expenses or treatment expenses and benefits which are due or to become due to me as a result of dental services. I authorize the payments to be paid directly to Joseph E. Kinder D.D.S, P.C. I am responsible to Joseph E. Kinder D.D.S, P.C. for payments made directly to me and for any services on charges not covered by my insurance carrier or workman's comp claim.

Signature____ **Date**__________________

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

Joseph E. Kinder D.D.S., P.C.

(260) 485-5530

AUTHORIZATION TO RELEASE PATIENT INFORMATION

PATIENT INFORMATION: *Please Print*

Patient Name: ____________________

Address: ____________________

____

SS# ____________________

DOB: ____________________

TYPE OF INFORMATION TO BE RELEASED:

_____ ***ALL INFORMATION OR:***

_____ Medical Information Only (specific date of service) ________

_____ Lab Results (specify date of service) ________

_____ X-Ray Reports (specify date of service) ________

_____ Surgical Records (specify date of service) ________

_____ Accident Information (specify date of service) ________

_____ Financial Information Only

_____ Other, please specify: ____________________

____

____

INFORMATION TO BE RELEASED TO:

Please check all that apply and please print names:

_____ Spouse, print name: ____________________

Phone: ____________________

_____ Father, print name: ____________________

Phone: ____________________

_____ Mother, print name: ____________________

Phone: ____________________

_____ Step parent(s), print name(s):

____________________ Phone ________

____________________ Phone ________

_____ Legal Representative: ____________________

Phone: ____________________

_____ Employer: ____________________

Address: ____________ Phone ________

City/State/Zip: ____________________

_____ Other (Attorney, Worker's Comp, Auto Carrier, etc.)

Name: ____________________

Relationship: ____________________

Address: ____________________

City/State/Zip: ____________________

Phone: ____________________

PURPOSE OR NEED FOR THIS INFORMATION: _____ **ANY**

(Must check one) _____ **OTHER, PLEASE SPECIFY:**

I hereby authorize Joseph E. Kinder D.D.S., P.C. to release information contained in my/patient's medical record to the above listed, as well as any person, corporation, or agency which is legally responsible or which Joseph E. Kinder, D.D.S., P.C. has good cause to believe is legally responsible, for processing and/or paying all or any part of Joseph E. Kinder, D.D.S, P.C. charges and/or professional fees; and, to any entity which has contracted with any insurer to conduct utilization or performance review. I hereby authorize Joseph E. Kinder, D.D.S., P.C. to release information to any physician or health care facility to which I may be transferred for further dental care.

Authorization is valid for five (5) years only and may be revoked in writing at any time prior to five (5) years by notifying Joseph E. Kinder D.D.S., P.C.

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already realeased information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

- Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Health Care Information" or
- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

Joseph E. Kinder D.D.S, P.C.
will not condition treatment based on the individual giving an authorization for the requested use or disclosure.

X____________________
Signature of patient or patient's authorized representative Date

X____________________
Relationship or status if signed by parent, legal guardian, personal representative, etc. Date

NOTICE OF PRIVACY PRACTICES: *By my signature below, I acknowledge that I have had the oppurtunity to review Joseph E. Kinder D.D.S, P.C.'s Notice of Privacy Practices. I understand that a written copy is available up on my request.*

X____________________
Patient/Parent/Guardian Signature Date

X____________________
Staff Signature Date