SUNRISE DENTAL

Dinah B. Vice, DDS PA III
Patient Registration

Date Created:

PATIENT INFORMATION

First Name:_____ Last Name:_____ Middle Initial:_____

Preferred Name:_____

Address:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Ext:_____

Cellular:_____

Birth Date:_____ Age:_____ Soc. Sec:_____

Email:_____

I would like to receive correspondences via e-mail: ☐

Sex:
☐ Male ☐ Female

Marital Status:
☐ Single ☐ Widowed ☐ Separated
☐ Divorced ☐ Married

Referred By:
☐ Family ☐ Val-Pak ☐ Insurance Co. ☐ Radio
☐ Internet ☐ Friend ☐ Other ☐ Sign/Drive by

If Other, please specify:_____

If Family/Friend, please specify:_____

Previous Dentist:_____

Responsible Party/Insured Information (If someone other than patient)

First Name:_____ Last Name:_____ Middle Initial:_____

Preferred Name:_____

Address:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Ext:_____

Cellular:_____

Birth Date:_____ Age:_____ Soc. Sec:_____

Email:_____

SUNRISE DENTAL

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

I, _____ understand that Dr. Vice and Associates are required to request this signature by federal law and acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Full Name: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other *(Please specify)*

Authorization to Release Information Purpose:

This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself, I _____ authorized the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Print Name/Relationship: _____

Print Name/Relationship: _____

Print Name/Relationship: _____

SUNRISE DENTAL

Authorization for Release of Information - Compound Release

Name of Patient _____ Date of Birth _____
is authorized to released protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays Other _____
☐ Spouse (provide name and phone number) _____	☐ Financial ☐ Medical
☐ Parent (provide name and phone number) _____	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *In order for email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Breach notification
☐ For email communication I understand that if email is not sent in an encryted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication.	
☐ Communication about treatment alternatives even if this office is being compensated for making the communication.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

*Description of personal Representative's Authority (attach necessary documentation)

Revised August 2013