PLEASE PRINT

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ◯ YES ◯ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE NUMBER

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ◯ SELF ◯ SPOUSE ◯ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SSN(US) / MEMBER ID#

GROUP / PROGRAM NUMBER	EMPLOYER - IF DIFFERENT FROM ABOVE	EMPLOYER'S ADDRESS	SECONDARY COVERAGE ◯ YES ◯ NO

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

I, _____ , HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

PLEASE PRINT 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:

CARTWRIGHT DENTAL

- ◯ COMMUNICATIONS BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT
- ◯ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT
- ◯ INDIVIDUAL REFUSED TO SIGN
- ◯ OTHER – *PLEASE SPECIFY*

_____

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

HEALTH CARE PROVIDERS INSURANCE COMPANIES ◯ YES ◯ NO

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I, _____, Date of Birth _____, request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, diagnosis (es), test results, date of services.

- ◯ SENSITIVE PROTECTED HEALTH INFORMATION
- ◯ YOU MAY DISCLOSE INFORMATION TO MY FAMILY MEMBERS AND/OR NON-FAMILY MEMBERS

PLEASE LIST THE NAME, PHONE NUMBER AND RELATIONSHIP

NAME	PHONE NUMBER	RELATIONSHIP
NAME	PHONE NUMBER	RELATIONSHIP

ASSIGNMENT AND RELEASE

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental healthcare insurance claim, (3) the use of my dental care records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and (5) my dentist's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by my insurance, I am obligated to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

SIGNATURE – PATIENT OR GUARDIAN	DATE	WITNESS SIGNATURE	DATE

If the above named Patient is a minor or unable to pay the his/her Uninsured Costs, the undersigned agrees to guaranty the payment of such Uninsured Costs to the Patient's dentist in accordance with his/her payment terms and policies.	SIGNATURE – GUARANTOR OF THE PATIENT	DATE