PRIMARY INSURANCE

Insured's Full Name _____ Birthdate _____

Insured's Employer, Address and Phone No. _____

Contract # _____ Group # _____ SS # _____

SECONDARY INSURANCE

Insured's Full Name _____ Birthdate _____

Insured's Employer Address _____ Ins. Phone No. _____

Contract # _____ Group # _____ SS # _____

As a courtesy to you, we file your insurance.

After 60 days patient is responsible for their balance in full, regardless of insurance status.

Acknowledgement of
PRIVACY PRACTICES

Steven A. Leach, D.M.D.
2002 Flint Rd., SE
Decatur, AL 35601
256-353-3211

My signature confirms that I have been informed of my rights to privacy regarding my rights to privacy, regarding my protected health information, under the Health Insurance Portability & 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 and indirectly.
- Obtain payment from third-party payers for my health care services.

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform the necessary forms of treatment, medication and therapy. I understand the use of anesthetic agents embodies a certain risk. I further authorize and consent to the use of this treatment.

I have been informed of my dental provider's Notice of Privacy Practice 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 the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may 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 Name _____ Date: _____

Signature _____
Patient or Guardian

PATIENT INFORMATION

Patient's name _____ Birthdate _____
Last First MI

Home Phone _____ Business Phone _____ Cell Phone _____ SS # _____

E-mail _____ ☐ Male ☐ Female ☐ Married ☐ Divorced ☐ Widowed ☐ Single

If patient is a minor, with whom does patient live? _____ SS# _____

Patient's home address _____

_____
City State Zip

Patient's or parent's employer _____ Business phone _____

Spouse _____ Employer _____ Business phone _____

Emergency Contact: Name _____ Phone _____

Relationship _____

Who may we thank for referring you to our office: _____

PATIENT'S MEDICAL HISTORY

Physician's name _____ Phone _____ Date last exam _____

Is patient presently under the care of a physician? ☐ Yes ☐ No If so, why? _____

Is patient presently taking any medication? ☐ Yes ☐ No If so, what? _____

Circle if you have or ever had a problem with the following:

AIDS / HIV
Allergies _____
_____
Anemia
Arthritis or Rheumatism
Asthma
Back Problems
Bleeding Disorder
Cancer
Chest Pain (Angina)
Diabetes
Dry Mouth
Epilepsy or Seizures
Heart Disease
Heart Murmurs
Hepatitis or Jaundice
High Blood Pressure
Low Blood Pressure
Joint Replacement
Kidney Disease
Liver Disease
Mitral Valve Prolapse
Nervous Disorder
Pacemaker
Pregnant
Recurrent Headaches
Rheumatic Fever
Sinus Problems
Stroke
Thyroid Disease
Tuberculosis
Other, Please list _____
_____
_____
Last Dental Visit _____

---------- For office Use only ----------

Patient elects not to pre-med for _____

Signature of Patient _____ Date _____

Witness _____ Date _____

Complete Insurance Information on back of this Sheet