ROBERT H. WALDMAN, D.D.S

PATIENT INFORMATION AND AUTHORIZATION FORM

Name	Nickname	Male Female	Today's Date
Birthdate	**Social Security#**	Single Married Divorced Widowed Separated	
Home address	City	State	Zip
Employer	Occupation		
Person responsible for account		Phone	
Whom may we thank for referring you?	Other family members seen by us:		

Phone Options	Phone Number	**It is okay to leave detailed message regarding appointments & treatment via phone/email/text**	Call this number
Home		Yes No	1st 2nd 3rd
CELL PHONE CARRIER-		Yes No **Text-** Yes No	1st 2nd 3rd
Work		Yes No	1st 2nd 3rd
Would you like to communicate by e-mail? ☐ Yes or ☐ No	E-mail Address:		

Confidentiality Communication Preference

List any other person(s) you authorize to receive relevant information about your care/treatment

Name	Relationship	Phone
Name	Relationship	Phone

Emergency Contact

Name	Relationship	Phone
Name	Relationship	Phone

Primary DENTAL Insurance

Insurance Co. name	Phone	Group# (Plan, Local, I.D. or Policy #)	
Insured's name	**Insured Social Security #**	Birthdate	Relation
Insured's employer			

Secondary DENTAL Insurance

Insurance Co. name	Phone	Group# (Plan, Local, I.D. or Policy #)	
Insured's name	**Insured Social Security #**	Birthdate	Relation
Insured's employer			

Primary MEDICAL Insurance

Insurance Co. name	Phone	Group# (Plan, Local, I.D. or Policy #)	
Insured's name	**Insured Social Security #**	Birthdate	Relation
Insured's employer			

Secondary/Supplemental MEDICAL Insurance

Insurance Co. name	Phone	Group# (Plan, Local, I.D. or Policy #)	
Insured's name	**Insured Social Security #**	Birthdate	Relation
Insured's employer			

A COPY OF OUR *DENTAL MATERIALS FACT SHEET* AND ROBERT H. WALDMAN'S D.D.S. *NOTICE OF PRIVACY PRACTICES* IS AVAILABLE UPON REQUEST.

I understand that I have rights regarding my protected health information. These rights are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) I have been informed of, and given the opportunity to review and secure a copy of Robert H. Waldman's D.D.S. Notice of Privacy Practices, which contain a complete descriptions of the uses and disclosure of my protected health information.

I understand that The Notice of Privacy Practices information serves as:

*A basis for planning my care and treatment.*A means of communication amongst the many healthcare professionals who contribute to my care. * A source of information for applying my diagnosis and surgical information to my bill.* A means by which a third-party payer can verify that services billed were actually provided. *The release of Medical/Dental information to Insurance companies.* A tool for routine healthcare operations, such as assessing care quality and reviewing the competence of healthcare professionals. *A means to ensure payment for services rendered.

I understand that I am responsible for payment at the time of service, unless other arrangements have been made. We will bill your insurance as a courtesy to you with a copy of your current insurance card. For your convenience we accept cash, check, credit cards and Care Credit. Please note that there is a $35 charge for checks returned by the bank for insufficient funds. Missed appointment and cancellations with less than 48 hours will incur a fee of at least $35.

I authorize the office of Robert H. Waldman D.D.S. to perform treatment after a discussion of risk, benefits & options.
I authorize the release of all Medical/Dental Information necessary to process my insurance claims and I authorize the release of the same information when necessary, to other providers rendering medical/dental care. I assign all medical, surgical and dental benefits including major medical benefits to which I am entitled to Robert H. Waldman, D.D.S. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient (parent if minor)____**Responsible Party:** ____________________**Date**____________

Witness (Office Staff Use Only) ____**Date**_____________________