PATIENT INFORMATION

Name _____
Last **First** **Initial**

Birthday_____ **Social Security #** _____

Address_____
Street **City** **State** **Zip**

Email_____

Cell Phone_____ **Work Phone**_____ **Home Phone**_____

Who may we thank for referring you to us?_____

Emergency contact: _____**Phone**_____

Relationship_____

Primary Insurance
Insured Name_____**Soc Sec#**_____**Birthdate**_____
Insurance Company_____**SubscriberID**_____
Group #_____ **Phone**_____

Main subscriber (self or spouse) ID#_____
Name_____**Phone**_____
Soc Sec#_____**Birthdate**_____

Secondary Insurance
Insured Name_____**Soc Sec#**_____**Birthdate**_____
Insurance Company_____**Subscriber ID**_____
Group #_____**Phone**_____

Main subscriber (self or spouse) ID#_____
Employer Name_____**Phone**_____
Soc Sec#_____**Birthdate**_____

_____ _____
Patient's or Guardian's Signature **Date**

LAGUNA NIGUEL SMILES
DENTISTRY

X-RAY CONSENT FORM

Patient Name: _____Date: _____

During your examination, the doctor may feel that X-rays/pictures will be needed in order to diagnose your condition. We would like to make you aware that X-rays may be required in order to administer treatment. In order to perform x-rays /pictures on any patient our office requires the patient's consent for such tests to be performed.

Please Choose One:

_____ I understand that my condition may require my doctor to take X-rays to diagnose my symptoms.

_____ I choose not to have X-rays at this time and release my doctor of all liabilities.

Please be advised X-rays and records request will have a charge of $50

Please allow 48 hours to process your request

Signature:_____ Date:_____

Females Only:

I understand that if I am pregnant and have X-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that ten (10days) following onset of a menstrual period are generally considered to be safe for X-rays exams. With those factors in mind, I am advising my doctor that :
I am pregnant _____ Yes _____No
I don't know if I could be pregnant _____Yes _____No

Signature:_____ Date: _____

LAGUNA NIGUEL SMILES DENTISTRY

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law.

You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.
The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you.
However, such a revocation will not be retroactive.
By signing this form, I understand that:

• Protected health information may be disclosed or used for treatment, payment, or healthcare operations. • The practice reserves the right to change the privacy policy as allowed by law. • The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions. • The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. • The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed_____

This consent was signed by: _____(PRINT NAME PLEASE)

Signature:_____ Date: _____

Witness: _____Date: _____