

# NEW PATIENT INFORMATION FORM

NAME (Last, First, Middle): \_\_\_\_\_ TITLE: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

PREFERRED NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

HOME PHONE: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ SEX: Male / Female REF. PATIENT/DOCTOR: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ EMERGENCY CONTACT (Someone not living with you): \_\_\_\_\_

MARITAL STATUS: SINGLE, MARRIED, DIVORCED, PARTNERED, WIDOWED: \_\_\_\_\_

## PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SS#: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ EMPLOYER ADDRESS: \_\_\_\_\_

PLAN NAME: \_\_\_\_\_ GROUP NO: \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_ IND YRLY DEDUCT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ FAMILY YRLY DEDUCT: \_\_\_\_\_

## SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SS#: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ EMPLOYER ADDRESS: \_\_\_\_\_

PLAN NAME: \_\_\_\_\_ GROUP NO: \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_ IND YRLY DEDUCT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ FAMILY YRLY DEDUCT: \_\_\_\_\_

## AUTHORIZATION OF ASSIGNED BENEFITS AND RECORDS RELEASE

I authorize Dr. Mary Lynne McElhaney to release dental information to submit insurance claims and for other physician's request relating to my dental care. I authorize payment of insurance benefits for any unpaid professional charges directly to Dr. Mary Lynne McElhaney. I understand that I am responsible for any amount not covered by my insurance.

Signature

Date

\_\_\_\_\_

\_\_\_\_\_

All charges are due at the time of service. If you have insurance, you are responsible for 50% at each visit. If insurance pays more than 50% we will issue you a refund check. If the insurance does not pay within 90 days, the full amount is due by the patient or responsible party.



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Mary Lynne McElhaney, DDS

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**Acknowledgement of Receipt  
Of Notice of Privacy Practices**

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Patient Name & Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have received a copy of the Notice of Privacy Practices for the above named practice.

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Signature

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Date

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For Office Use Only

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**We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:**

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:  
\_\_\_\_\_
- Other: \_\_\_\_\_  
\_\_\_\_\_

Prepared By \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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