Patient Information Date: _____

Name: _____ S.S#: _____

Home Telephone: _____ Work Phone: _____

Cell Number: _____

E-mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____ Male: ___ Female: ___

Circle One: Married Widowed Single Divorced Separated Minor

Patient Employer/School_____

Occupation_____

Whom may we Thank for referring you?_____

In case of emergency who should be notified?_____ Phone _____

Responsible Party Information (if different than patient)

Person responsible for Account: _____

Relation to Patient: _____ Birthdate: _____

S.S#: _____ Cell Number: _____

Address (if different from pt.): _____

City: _____ State: _____ Zip: _____ E-mail: _____

Dental Insurance

Insurance Company: _____ Employer: _____

Subscriber Name: _____ DOB: _____ S.S#: _____

Plan #: _____ Subscriber #: _____ Group #: _____

Ins. Phone: _____

Drs. Brian & Amy Case
503 N. Nolan River Rd • Cleburne, TX 76033
(817) 517-6453
www.nolanriverdentalcenter.com

Section A: Acknowledgement of Receipt of Privacy Practices Notice. –
I, _____, acknowledge that I have received a Notice of Privacy Practices from the above name practice.
Signature: _____ Date:_____

If a representative signs this authorization on behalf of the individual, complete the following:
Representative's Name: _____
Relationship to Patient: _____

Section B: Patient Consent for Medical Photography - I consent for medical photographs to be made of me or my child(or person for whom I an legal guardian). I understand that the information may be used in my medical record, for purposes of diagnosis, referrals, medical teaching, or for publication in medical textbooks or journals. By consenting to these medical photographs I understand that I will not receive payment from any party.
Name:_____ Signature:_____

Information Release: I consent for my information to be given to only the following people:
Name: _____ Relation: _____
Name: _____ Relation: _____

Section C: For Office Use Only - I attest that the above information is correct.
Signature: _____ Date: _____
Print Name: Julia Damota/Bacardi Exline Title: Office Coodinator

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