

## New Patient Information

Date\_\_\_\_\_

Name\_\_\_\_\_ Male\_\_\_\_\_Female\_\_\_\_\_  
Last First Middle

Address\_\_\_\_\_City\_\_\_\_\_

State\_\_\_\_\_Zip\_\_\_\_\_ Home Phone#\_\_\_\_\_

Business phone #\_\_\_\_\_Other phone #\_\_\_\_\_

Social Security\_\_\_\_\_ Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation\_\_\_\_\_  
Mo day year

Email address\_\_\_\_\_ Referred by\_\_\_\_\_

Marital Status\_\_\_\_\_ Spouses name if applicaible\_\_\_\_\_

Person to contact in case of emergency\_\_\_\_\_

Relationship\_\_\_\_\_ emergency contact phone #\_\_\_\_\_

Chief Dental Complaint \_\_\_\_\_

Responsible Party\_\_\_\_\_ Do you have Dental Insurance Coverage? Yes No

**Dental Insurance Information:** Primary cardholder's name\_\_\_\_\_

Cardholder's employer\_\_\_\_\_ Cardholder's social security number\_\_\_\_\_

Cardholder's Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo day year

**Notice of Privacy Practices:** Please read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of how we use and protect your health and personal information. We encourage you to read it carefully before signing. We reserve the right to change our policy. You may obtain a copy of our Notice of Privacy Practices at anytime by contacting our office.

**Right to Revoke:** You will have the right to revoke this consent at any time by giving us written notice.

**Signature:** I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that by signing I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I have been offered a copy of our Notice of Privacy Practices.

**Signature**\_\_\_\_\_

**Financial Policy:** I understand that I am fully responsible for the balance of my account due at the time services are preformed.

**Signature**\_\_\_\_\_

**Consent for treatment:** I give Eric Schorn DDS and/or Amy Schorn DDS permission to perform procedures including but not limited to: giving anesthesia and medications, making radiographs and photographs, cleaning and exams, restoring and removing teeth, root canals and any other procedures necessary for my dental therapy.

**Signature**\_\_\_\_\_