



Barrett L. Bartell, D.D.S., P.A. Tom C. Howorth, D.D.S.

Patient Information Form

This form was created to help our team learn more about you, your wishes and needs. Please read through and complete each section (Front and Back), as it pertains to you.

Dr. Mr. Mrs. Ms. _____ Child Male Female Date _____
Marital Status

Patient's Last Name Patient's First Name Middle initial

Patient Prefers to be Called (Name and/or Title): _____ Spouse Name _____

Birth Date: _____ Age: _____ SS# _____ Driver's License # _____

Address: _____
Street City State Zip Code

(_____) _____ (_____) _____ (_____) _____
Home Phone Work Phone Cell Phone

Do you prefer to be contacted by e-mail or phone? E-mail Phone

E-Mail Address for appointment reminders In the event of an emergency, who should we contact? (_____) _____

Who may we thank for referring you to our office? Patient's Place of Employment or School Patient attends

Who is responsible for payment on the Patient's Account?
 Self Spouse Father Mother Other

Responsible Party: _____
Last Name First Name Middle Initial

Address: _____
Street City Zip Code

(_____) _____ (_____) _____ (_____) _____
Home Phone Work Phone Cell Phone

(Please complete other side of form)

Welcome To Our Practice

**I UNDERSTAND MISSED OR BROKEN APPOINTMENTS WITHOUT A 24 HOUR
ADVANCED NOTICE IS SUBJECT TO A \$35.00 FEE.** _____

Initial

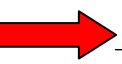


WE DO NOT ACCEPT INSURANCE ASSIGNMENT. PAYMENT IS DUE ON THE DATE OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. AS A SERVICE TO YOU WE WILL BE HAPPY TO PUT YOUR INSURANCE INFORMATION INTO OUR COMPUTER SYSTEM AND GIVE YOU AN INSURANCE FORM FOR YOU TO SUBMIT TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT.

_____ Name of Policyholder		_____ Relationship to Patient		_____ Policyholder Birth Date	
_____ Soc. Sec. # or Member #	_____ Employer	_____ Insurance Company		_____ Group Number	
_____ Insurance Company Address		_____ City	_____ State	_____ Zip Code	
Insurance Phone Number (_____) _____					

AUTHORIZATION:

I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior to treatment, the doctor and/or his staff will give a full explanation of the procedure(s) involved. I agree to pay for all services rendered by this office. I also consent to the use of periodic appointment reminder phone calls and/or appointment reminder items sent via mail. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered at this office.



_____ Signature of patient (or Guardian)	_____ Date
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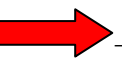
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations.

I acknowledge that I have read or can ask for a copy of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that, withholding my signature means I have refused my consent for you to disclose my information to my insurance providers, payment providers and any other of my healthcare professionals.



_____ Signature of Patient (or Guardian)	_____ Relationship to Patient	_____ Date
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