NEW PATIENT AND HIPAA FORM

PATIENT INFORMATION

Patient First Name:	Patient Last Name:	Preferred Name:
Gender: Male Female Preferred Pronoun Non-Binary	Date of Birth:	Patient Cell Phone Number:
General Dentist and Location:	What brings you in today, concerns?	
Other family seen at Peak Orthodontics:	How did you hear about us?	

RESPONSIBLE PARTY INFORMATION

First Name:	Last Name:	Relationship to patient:
Address:	City:	Zip Code:
Cell Phone Number:	Email Address:	Date of Birth:

EMERGENCY CONTACT

(Friend or Relative NOT living with you.)

First Name:	Last Name:
Cell Phone Number:	Relationship to patient:

PRIMARY DENTAL INSURANCE INFORMATION

Please give your insurance card to the receptionist

Dental Insurance Company Name:	Policy Holder's First Name:	Policy Holder's Last Name:
	Policy Holder's Social Security#:	Policy Holder's Date of Birth:
Group Number:	Policy Number:	Employer:

SECONDARY DENTAL INSURANCE INFORMATION

Dental Insurance Company Name:	Policy Holder's First Name:	Policy Holder's Last Name:
	Policy Holder's Social Security#:	Policy Holder's Date of Birth:
Group Number:	Policy Number:	Employer:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Peak Orthodontics.
I understand that I am financially responsible for any balance. I authorize Peak Orthodontics to release any information required to process my claims.

Notice of Privacy Practices HIPAA

Federal and local laws require that privacy practices be disclosed. By signing below, I acknowledge that I have read a copy of Peak Orthodontics "Notice of Privacy Practices." I may receive a copy of this upon request for my own records.

Patient/Responsible Party signature

Date