Full Name: _____ SS#_____ Birth Date: _____

Address: _____

[ ] APT [ ] LOT [ ] SPACE: _____ City: _____ State: _____ Zip: _____

Main Phone: (____) ____-_____ Work Phone: (____) _____-_____ EXT: ____ Alternate Phone: (____) _____-_____

Email Address: _____ @ _____._____

Sex: [ ] M [ ] F [ ] Other _____ **Marital Status**: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

Employment Status: [ ] Full Time [ ] Part Time [ ] Retired [ ] N/A **Student Status**: [ ] Full Time [ ] Part Time [ ] N/A

Preferred Pharmacy: _____ Location: _____ Phone: (____) ____-_____

Primary Care Physician: _____ Location: _____Phone: (____) ____-_____

Emergency Contact:

Name: _____ Phone: (____) ____-_____ Relation: _____

Consents:

The following forms provide information regarding your dental care at Brush Dental. You will receive a copy of each document. ***Your initials and signature below*** *indicate that you received a copy, understand the information, and agree to the terms and conditions outlined in all the documents given.*

- ☐ _____ **Brush Dental Information Sheet** - this document shares basic information all patients should know.
- ☐ _____ **Consent of Treatment** - this document allows you and any family members 17 and younger to which you are parent or legal guardian to receive dental treatment at Brush Dental.
- ☐ _____ **HIPAA Notice of Privacy Practices** - the notice provides information on the use of your health information.
- ☐ _____ **Patient** F**inancial Rights & Responsibilities Policy** - this policy informs you that Brush Dental expects payment for the services on the date of service provided and to keep your insurance information up to date so we may bill your services when necessary.
- ☐ _____ **Medicaid & CHP+ Agreement & Policy - this policy informs you of your right as responsibilities as a Health First Colorado Patient**
- ☐ _____ **Missed and Late Appointment Policy** - Missing appointments or arriving 10 or more minutes late may result in dismissal of services from Brush Dental.
- ☐ _____ **Authorization to Release Information to Family Members** - Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent.
  Please provide the necessary information if you would like to authorize someone.

Name: _____ Relation to Patient: _____ Phone # _____

- ☐ _____ **Authorization to Leave Detailed Messages -** To expedite the receipt of the needed information, please indicate below if you would like to give consent to leave detailed messages. I authorize Brush Dental to leave all pertinent information on my voicemail, email, or text message.
  Most preferred method of communication: [ ] Phone call [ ] Text Message [ ] E-mail
  I would like to receive: [ ] Appointment reminders [ ] Insurance information [ ] Billing statements

X_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN **TODAY'S DATE**

(Signing this form authorizes care for both yourself and any dependents you have included on the child registration form attached)