18 E. WASHINGTON ST.
GREENCASTLE, IN 46135
P: (765) 653-8615
F: (765) 653-5227

PATIENT INFORMATION

(Please Print in Blue or Black Ink)

Date______________________

First Name ________________________________ Middle Initial _____ Last Name______________________________

Preferred Name ________________________________ Email Address ____

Address ______________________________________ City __________________________ State _____ Zip _________

Date of Birth___________________ Age_____Social Security #__________________________ Sex: □ Male □ Female

Home Phone (_____) __________________ Work Phone (_____) ________________ Cell (_____) __________________

Best Contact Number: □ Home □ Work □ Cell May we call you at work? □ Yes □ No

Referred By ____

Student: □ Full Time □ Part Time □ No School Name/Address____

Marital Status: □ Married □ Divorced □ Separated □ Widow □ Single Spouse Name________________________

Patient Employed: □ Full Time □ Part Time □ Retired □ No

Employer Name/Address____ Phone #__________________________

Name of person responsible for this account ______________________________ Relationship to patient____________

Parent or Guardian Information (If minor)

Name: ____ Home Phone (___) _____________ Cell (___) ____________

Address______________________________________City__________________________ State______ Zip_____________

Employer Name/Address____ Phone #__________________________

IN CASE OF EMERGENCY NOTIFY: Name:________________________________ Phone # (_____)___________________

INSURANCE IMFORMATION

Please Present Insurance ID Cards to Receptionist

PRIMARY **DENTAL** INSURANCE

Insurance Company _______________________________

Employee Name __________________________________

Employee Birthdate_______________________________

Patient Relation To Employee:

☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Phone # (____) ___________________________

Group # ____

Employee SSN ___________________________________

Employer____

Bus. Phone # (____)_________________________________

SECONDARY **DENTAL** INSURANCE

Insurance Company _______________________________

Employee Name __________________________________

Employee Birthdate _______________________________

Patient Relation To Employee:

☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Phone # (____) ___________________________

Group # ____

Employee SSN ___________________________________

Employer _______________________________________

Bus. Phone # (____)_________________________________

→
turn over

INSURANCE, AUTHORIZATION, AGREEMENT OF FINANCIAL RESPONSIBILITY AND TREATMENT CONSENT

By my signature below I authorize the following: use of this form on all my insurance submissions, release of information to all my insurance carriers, my dentist to act as my agent in helping me obtain payment from my insurance carriers, payment directly to my dentist, and a copy of this authorization to be used in place of the original.

By my signature below, I consent to dental treatment.

By my signature below, I agree that I am responsible for my payment of any or all of the following: all fees not paid by my insurance including, but not limited to deductibles, co-pays, and disallowed services; any interest or fees assessed to my account for past due balances; all costs including, but not limited to, reasonable attorney fees, collection fees, and court costs.

Signature ______________________________ Date ______________________

Printed Name ________________________ Relationship ______________________
(If patient is a minor)

PATIENT CONSENT TO SHARE PROTECTED HEALTH INFORMATION

Patient Name ______________________________ Date ______________

I hereby consent to **Elizabeth A. Kirsch, D.D.S., Perry A. Wainman, D.D.S. and/or staff of Kirsch Family Dentistry, LLC leaving a voicemail message at the number(s) indicated below and/or discussing with the individual(s) the information related to my protected health information (PHI). These communications may include, but are not limited to, appointment reminders, medications, pre-registering, billing and insurance items, and any information pertaining to clinical health services.**

With my consent, Elizabeth A. Kirsch, D.D.S., Perry A. Wainman, D.D.S. and/or staff of Kirsch Family Dentistry, LLC may disclose my PHI with the following individuals:

Name: ______________________________ Phone Number: __________
Name: ______________________________ Phone Number: __________
Name: ______________________________ Phone Number: __________

I understand the information listed about may be communicated via: fax, photocopy, verbal communication, telephone, voice mail/and or direct mail.

If certain information is NOT to be included, please list: ______________________________

YOUR RIGHTS WITH RESPECT TO THIS CONSENT:
I understand that I have the right to revoke this consent at any time by completing a new form.

____

Signature of Patient or Legal Representative **Date**

(If signed by Legal Representative, state relationship and authority to do so)

Patient is ☐ **Minor** ☐ **Disabled** ☐ **Other – List** ____________________

Legal Authority: ☐ **Custodial Parent** ☐ **Legal Guardian**

☐ **Authorized Legal Representative**