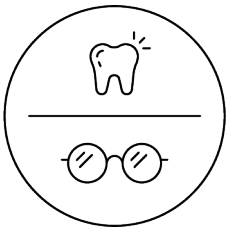

Stanford Family Dental and Vision

Established Patient Information

Name:_____ Date of Birth:_____ __Male __Female

Social Security Number:_____ Email:_____

Mailing Address:_____ City/State:_____ Zip Code:_____

Home Number:_____ Cell Number:_____

Emergency Contact Name & Phone Number:_____

How will you pay for today's visit? ___Vision Insurance ___Medical Insurance ___Dental Insurance ___ Private Pay

Insurance Information

Subscriber Name:_____ Subscriber Date of Birth:_____

Subscriber's Employer:_____ Subscriber Social:_____

Circle Purpose of Today's Visit: Vision (Glasses, Contacts, Medical) Dental

Are you allergic to: __Penicillin __Latex __Sulfa __Aspirin __Codeine
__ Local Anesthetics __Acrylic __Metal

Are you pregnant? ___Yes ___ No Are you nursing? ___ Yes ___ No
Do you use? ___ Tobacco ___ Alcohol ___ Controlled Substance

List any **CHANGES** in ALLERGIES:_____
_____

List any **CHANGES** in MEDICATIONS:_____
_____

Signature:_____ Date:_____

AUTHORIZATION TO RECEIVE TREATMENT AND THE ASSIGNMENT OF BENEFITS

Please read and agree to the following:

1. I authorize this office to perform any necessary treatment that I may need.
2. I authorize this office to bill my insurance for any and all services but understand that I am ultimately financially responsible in the event that my insurance does not pay for services.
3. I agree that all services rendered are due payable at the time of service.

ACKNOWLEDGMENT OF RECEIPT OF HIPAA

I acknowledge that I read a copy of Stanford Family Dental & Vision, LLC Notice of Privacy Practices.

If you would like to amend any of the privacy practices, please state below:_____

Is there anyone other than yourself that has permission to receive or discuss your care or needs? If so, list their name and contact number:

_____

_____

Please check the allowable means of communication: _____e-mail _____text

Signature of PATIENT (if you are under 18, a guardian must sign)

X_____ Date:_____