Today's Date _____Who may we thank for referring you? _____

Patient's Name Last _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Cell ( ) _____ Birthdate _____SSN# _____

Patient's Employer _____ work Phone ( ) _____

Email: _____ Marital Status: Married _____ Single _____ Widowed _____

INSURANCE INFORMATION

Insured's Name _____ Birthdate _____ SSN# _____

Insurance Co _____

Ins Co Address _____ City _____ State ___ Zip _____

ID# _____ Group# _____ INS CO Phone ( ) _____

If you have secondary Insurance

Insured's Name _____ Birthdate _____ SSN# _____

Insurance Co _____

Ins Co Address _____ City _____ State ___ Zip _____

ID# _____ Group# _____ INS CO Phone ( ) _____

Patient's initials required

_____ As a courtesy we shall bill any dental insurance the patient may have. Any fees for services rendered that are not covered by such insurance are the responsibility of the financially responsible party. Unless previous financial arrangements have been made, payment of the patient's portion of doctor's fees is expected at the end of each procedure/visit.

_____ The office of Dr. Nicole Pagonis reserves the right to charge a fee of $50.00 for cancellations made with less than 48 hour notice!

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 providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your notice of Privacy Practices containing 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 I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are NOT required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ Date: _____