# PERSONAL INFORMATION

## Contact Information

| | | |
|---|---|---|
| Name: | Home Phone: ( ) | Cell Phone: ( ) |
| Address: | City: | State: Zip: |
| Email: | Date of birth: | Sex: M F |
| Dental Insurance Company: | Social Security #: | |
| Emergency Contact: | Relationship: | Emergency Contact Phone: |
| Preferred Pharmacy: | | |

## Release and Authorization

I authorize release of any information relating to this claim. I understand I am responsible for all costs of dental treatment. I hereby authorize payment of dental benefits otherwise payable directly to me to the dental entity Gilbreth Endodontics.

Signature: Date:

## PRIVACY PRACTICES

I certify I have been made aware of Gilbreth Endodontics' Privacy Policy and that I have a right to receive a copy upon request. This notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Gilbreth Endodontics health care operations. The Notice also describes my rights and Gilbreth Endodontics duties with respect to my protected health information. I understand that copies of the Notice of Privacy Policy are available in the registration areas of each facility and on the web at: www.gilbrethendo.com. I may request that a copy be mailed to me by calling 505-903-6916.

Gilbreth Endodontics reserves the right to change the privacy practices that are described in the Privacy Policy. I may obtain a revised Notice by calling the above number and requesting a copy be mailed to me, or by asking for one at my next appointment, or by accessing it online at website listed above to view the most current version.

Signature: Date: