DRS. LEVY & VUTERA

FAMILY DENTISTRY

Patient Info: Name: Last:		First:	Nickname:
Date of Birth:	Sex: (circle one) Male Female	Social Security Number:	
Address:			
City:	State and Zip:	Marital Status:	
Email Address:			
Home Phone:	Work phone:	Cell Phone:	
Responsible Party Info: Name: Last		First:	
Date of Birth:	Sex: (circle one) Male Female	Social Security Number:	
Address:			
City	State:	Zip:	
Emergency Contact Info: Name:		Phone:	
Referred by:		Previous Dentist:	
Insurance Info: Company:		Employer:	
Policy Holder:		Social Security Number:	
DOB:	Address:		
City:	State:	Zip:	

I acknowledge that I have had the full opportunity to read and consider the contents of the Notices of Privacy Practices. I understand that, by signing this form, I am giving my consent to Levy and Vutera Family Dentistry to the use and disclosure of my protected health information to carry out treatment, payments and health care operations.

Signature: _____ Date: _____