Patient Account Information

Kathleen A. Varley, D.D.S.
James J. Varley, D.D.S.

Patient Information

Name _____ Date ___/___/___

Address _____ DOB ___/___/___

_____ SS# ___-___-___

Phone # (___) ___-___ Please circle: HOME WORK MOBILE

Phone # (___) ___-___ Please circle: HOME WORK MOBILE

Phone # (___) ___-___ Please circle: HOME WORK MOBILE

Previous Address _____

(If less than 2 years at current address)

Employer/ Occupation _____

Patient Insurance Information

Name of Insured *(If other than the Patient)* _____

Insurance Company Name _____

Subscriber ID # _____ Group # _____

Spouse Information

Name _____ DOB ___/___/___ SS# ___-___-___

Employer/ Occupation _____ Work Phone # (___) ___-___

Spouse Insurance Information

Name of Insured *(If other than the Patient)* _____

Insurance Company Name _____

Subscriber ID # _____ Group # _____

Person Responsible for Payment *(If other than Patient)*

Name _____ DOB ___/___/___

Address _____ SS# ___-___-___

Relationship to Patient _____ Contact Phone # (___) ___-___

Previous Dentist _____

City, State _____

Date of Last Treatment ___/___/___

Who referred you to us? _____

Emergency Contact _____

Relationship to Patient _____

Contact Phone # (___) ___-___

I hereby authorize payment directly to Dr. Varley of insurance benefits otherwise payable to me.
I authorize release of information about my treatment relating to claims filed.

Signature of Patient _____ Signature of Insured _____

HIPAA Acknowledgement

Kathleen A. Varley, D.D.S.
James J. Varley, D.D.S.

I understand that, under the Health Insurance Portability and 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 multiple healthcare providers who may be involved in my treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by this office of its Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I am aware of my right to review such Notice of Privacy Practices prior to signing this consent. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact the office to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that this office restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand this office is not required to agree to my requested restrictions, but if the office does agree, the office is bound to abide by such restrictions.

I understand that I may revoke this consent, in writing, at any time, except to the extent the office has already taken action relying on this consent.

Patient Name (Please Print): _____

Patient Signature: _____

Relationship to Patient (If not Self): _____

Today's Date: _____