

# ACQUAINTANCE FORM



Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
Person Responsible for Account: \_\_\_\_\_  
Do you have dental insurance? \_\_\_\_\_ Name of Dental Plan: \_\_\_\_\_  
How did you hear about office? \_\_\_\_\_  
Emergency contact/phone # \_\_\_\_\_  
Medical Clinic/Doctor: \_\_\_\_\_

## CONSENT AND ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES

- I, \_\_\_\_\_, have received a copy of this office's notice of privacy practices. I also authorize the disclosure of my health information as described below. We cannot refuse to treat you if you choose not to sign this authorization.
- It is the office policy of Oak Grove Dental, P.A. NOT to release Private Health Information regarding your treatment to anyone, except for:
  - Parent/legal guardian
  - Other persons authorized by the patient
  - As we may reasonably infer from the circumstances (Example: if you bring a family member or friend into the treatment room it will be assumed that person may receive information regarding your treatment)
  - In emergency situation or as otherwise permitted by HIPAA

If you anticipate that you will want or need health or financial information to be provided to family members, friends, or caretakers/babysitters, please put their name(s) below, so that we may best serve you. Be sure to circle what information you want or do not want shared. Example: if you want only health information to be shared with Aunt Ruth, be sure to indicate "yes" for health care information and "no" for Financial.

	Health	Financial
Spouse: _____	Y/N	Y/N
Parent: _____	Y/N	Y/N
Other: _____	Y/N	Y/N

\*Please list current email address \_\_\_\_\_

By signing below, you authorize that the above named people may/may not receive information regarding your care and finances, and the contact numbers provided we are allowed to leave a detailed message. NOTE: If you wish to cancel or change this agreement, please inform our office in person, in writing or by calling our office. This Authorization may be cancelled to the extent allowed by law. If you do cancel this authorization, you understand that Oak Grove Dental may have already released information about you after you gave your original permission.

**\* Please present photo ID and current dental insurance card**

PRINTED NAME \_\_\_\_\_

\_\_\_\_\_  
Patient or Parent/Guardian Signature

\_\_\_\_\_  
Date