GROVE DENTIST

Dr. Florin S. Alb, DDS
7916 Main Street N Maple Grove, MN 55369
Phone: 763.420.8038

PATIENT INFORMATION

Full Name	Date of Birth	Gender	SSN	Marital Status
Address	City	State	Zip	
Phone Numbers		Email		

EMERGENCY CONTACT INFORMATION

Name	Relationship	Phone number
Name	Relationship	Phone number

INSURANCE INFORMATION

Dental Insurance	Subscriber ID Number	Group Number
Policy Holder's Name	Policy Holder's DOB	Employer Name
Person Responsible for Account		Phone Number

Thank you for choosing Grove Dentist as your dental health care provider. We are committed to providing you the best treatment possible. Your signature below acknowledges our office policies below.

*The information listed above is correct to the best of my knowledge. I authorize the administration of medication and performance of the dental procedures recommended by my dentist. I understand that the recommended treatment is a decision made between myself and my dentist, and is not planned around insurance company coverage.

*I authorize Grove Dentist to send insurance claims on my behalf. Although I may be given a financial estimate, I am responsible for my balance regardless of the insurance estimate provided. This balance is due upon receipt of statement.

*I understand that Grove Dentist's company policy requires a 24 hour notice to change or cancel my reserved appointment and if this notice is not met, I may be charged a $25 cancelation fee or may no longer be able to reserve an appointment time.

X **Signature:** _____ **Date:** _____

GROVE DENTIST

Dr. Florin S. Alb

Patient Name: _____ **Patient DOB:** _____

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

X **Signature:** _____ **Date:** _____

ADDITIONAL CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

To help with my care of billing, Grove Dentist can share my protected health information with the following individuals:

Name:_____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

NONE: ☐

Authorized shared information includes scheduling, billing, dental treatment, and health conditions. Our team will be authorized to release information to the parties listed above. This form does not have an end date, if you would like to change this information you will need to contact our office and fill out a new form.

X **Signature:** _____ **Date:** _____

We would like to Thank your family member/ your friends/ or the company that referred you.

Name _____ Phone: _____ email: _____