HOUSTON ORAL HEALTHCARE SPECIALISTS

1110 KINGWOOD DR. STE 105. KINGWOOD TX 77339 P.832.777.0038 WWW.HOHCS.COM

Personal Information

Patient Name

Mr/Mrs/Ms____

Address ____

City _____________________________State_____Zip Code________________

Placem of Employment____________________Occupation___________________

Home Number_________________________Cell Number____________________

Date of Birth______________ Email Address______________________________

Referred By____

Name of Family Member Already a Patient Here___________________________

Name of Parent or Guardian ____

Patient Acknowledgment for receipt of Notice of Privacy Practices consent/limited Authorization and Release form

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date____________________

The undersigned acknowledges receipt of a copy of the currently effective Noitce of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be effective as the original. MY SIGNATURE WILL ASLO SERVE AS A PHI DOCUMENT RELASE SHOULD I REQUEST TREATMENT OF RADIOGRAPHS TO BE SENT TO OTHER ATTENDING DOCTOR(S)/FACILITIES IN THE FUTURE.

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Print name of Patient

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Signature of Patient/Guardian/Legal Representative

Please list any other parties who are actively involved in your health care and who can have access to your health information.

Name_______________________________________***Relationship***________________________

Name of General Dentist/Referring Dentist____

This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your acknowledgement and consent.