Oral & Maxillofacial Surgery Patient Information

Michael C. Mistretta, DDS, MD, FACS

Welcome to our office; please complete this form as it is required to create your office record. Please note that all information is kept confidential.

Patient's Name: ____ Today's Date: ________________

Sex: _____ Age: ______ Birth Date: ______________________

Patient Social Security #:____

Address: ____

City: ___________________________ State: ________________________ Zip: ________________

Home Phone: ______________________ Cell Phone: ____

Work Phone: ______________________ Email:____

Emergency Contact Name and Phone Number: ____

Referring Dentist/ Health Center: ____

Responsible Financial Party's Name: ____

Relationship to Patient: ____

<u>NOTICE OF HIPAA PRIVACY POLICY</u>

I acknowledge that I have received and/or had the opportunity to review the HIPAA privacy policy and regulations of this office, which describes the uses and disclosures of protected health information (PHI) that may be made by a practice or provider, the individual's rights, and the legal duties of the practice or provider with respect to PHI.

Patient/Representative Signature: ____

Date: _____________