NEW PATIENT INFORMATION

Full Name _____Preferred Name_____

Spouse's Name _____Parents Name if Child _____

Address _____ City _____Zip _____

Home Phone _____ Cell Phone _____Birthday _____

Social Security _____

Email Address _____Referred By _____

How do you prefer to be contacted for appointments?

Phone: Home or Cell Text Email

Dependent Children Name _____Age _____

Name _____Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

THE HILL DENTAL GROUP

Authorization for Communication of Protected Health Information to Family Members and Friends

1. **I, _____authorize The Hill Dental Group PLLC to discuss/share protected health information about me with the following individual(s) who are involved in my care:**

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

2. **Type of information to be shared or disclosed:**

   - □ Appointment information
   - □ Prescription information
   - □ Account information
   - □ Dental treatment/records
   - □ ALL information

3. **I authorize The Hill Dental Group PLLC to leave detailed messages about my dental and health plan information with the following:**

   - □ Voicemail
   - □ Person answering
   - □ Email
   - □ Text messaging

This authorization shall remain in effect until revoked in writing by the patient. Submitting a new form will revoke existing form.

I DO NOT AUTHORIZE THE HILL DENTAL GROUP TO DISCUSS/SHARE PROTECTED HEALTH INFORMATION ABOUT ME._____(please initial)

Signature of Patient/Authorized Individual Date