TED A. JOWETT
FAMILY DENTISTRY
live life smiling!

Patient Information

Today's Date: ____/____/____

Name: _____ Preferred Name: _____
Social Security #: _____ Age: _____ Birthdate: ____/____/____
Address: _____ Zip _____
Email: _____
Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____
For appointment reminders, may we text you? _____
Employer: _____ Occupation: _____
Marital Status: _____ Do you have children: _____ How many? _____
Spouse's Name: _____ Phone #: _____
Who may we thank for referring you to our office? _____

Person Responsible for Account: _____ Relationship to patient: _____
Social Security #: _____ Birthdate: ____/____/____
Address: _____
Phone #: _____ Employer: _____

Who should we contact in the event of an emergency?
Name: _____ Relationship: _____
Phone #: _____
Medical Doctor: _____
Phone #: _____

Insurance Information

Primary Insurance Name: _____ Phone #: _____
Address: _____
Insured's Name/Relationship: _____ Birthdate: ____/____/____
Social Security #: _____ Insured's Employer: _____
Member/Subscriber #: _____ Group #: _____

Secondary Insurance Name: _____ Phone #: _____
Address: _____
Insured's Name/Relationship: _____ Birthdate: ____/____/____
Social Security #: _____ Insured's Employer: _____
Member/Subscriber #: _____ Group #: _____

****It is the patient's responsibility to know and understand his/her own dental insurance benefit coverage, limits, waiting periods, etc. The patient is ultimately responsible for payment for all services rendered by Dr. Jowett Family Dentistry, and the patient must pay for any services not covered by the patient's insurance company.***

I understand the above information and guarantee this form was completed correctly to the best of my knowledge, and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ **Date:** ____/____/____

Ted A. Jowett, DDS, 1017 SW Gage Blvd., Suite C, Topeka, KS 66604 Phone: 785-272-3864 Email: info@jowettdds.com Fax: 785-272-3151

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____ Zip_____

Telephone: _____ Social Security Number: _____

Email: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available by request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time, by contacting:
Ted A. Jowett, DDS - Phone: 785-272-3864 Email: info@jowettdds.com Fax: 785-272-3151

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE: I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I agree that the office of Ted A. Jowett, DDS can collect, use and disclose personal information about (Patient's Name) _____ as set out above in the information about the office's privacy policies.

Signature: _____ Date: _____

Optional Consent

(Allows us to discuss treatment or finances with Parents, Spouse, Children, Secretaries, etc., as you designate)

I agree that the office of Ted A. Jowett, DDS can discuss treatment, arrange appointments, discuss fees, and make financial arrangements with the following people:

Name/Relationship: _____ Signature:_____

Name/Relationship: _____ Signature:_____

You are entitled to a copy of this consent after you sign it.