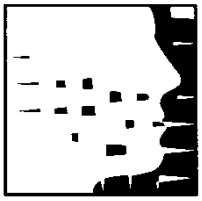

Ben F. Tarsitano, DDS, MD

Diplomate, American Board of
Oral &Maxillofacial Surgery

70B Penny Lane • Watsonville, CA 95076 • (831) 722-8887 • (831) 722-2762 fax
640 E. Alvin Drive, Suite C • Salinas, CA 93906 • (831) 443-9300 • (831) 443-9336 fax

PATIENT INFORMATION

Name _____ SS# _____ Sex: □ Male □ Female
Last First M.I.

Address _____
Number Street Name Apt/Space # City State Zip

Tel. # _____ Cell# _____ E-mail _____

Date of Birth _____ Age _____ Marital Status: □ Married □ Single □ Divorced □Widowed

In case of emergency, please contact _____ Tel. # _____ Relation _____

Driver's License # _____ If full time student, name of school _____

Have you been a patient of our practice? □ Yes □ No Referred by _____

Dentist _____ Physician _____

ACCOUNT INFORMATION

Who will be responsible for this account? □ Self (If self, skip this section) □ Father □ Mother □Other _____

Name _____ SS# _____ Birth Date _____ Age _____
Last First M.I.

Address _____
Number Street Name Apt/Space # City State Zip

Tel. # _____ Cell# _____ E-mail _____

Employer _____ Telephone # _____ Driver's License # _____

INSURANCE INFORMATION (Please provide insurance card to receptionist to obtain copies for proper billing and benefit verification)

□ Dental □Medical
Insurance Company Name _____ ID #_____
Address _____ Tel. # _____ Group # _____
Insured Party _____ Relation _____ Birth Date _____
Sex: □Male □ Female SS# _____ Tel.# _____
Address _____

□ Dental □Medical
Insurance Company Name _____ ID #_____
Address _____ Tel. # _____ Group # _____
Insured Party _____ Relation _____ Birth Date _____
Sex: □Male □ Female SS# _____ Tel.# _____
Address _____

□ Dental □Medical
Insurance Company Name _____ ID #_____
Address _____ Tel. # _____ Group # _____
Insured Party _____ Relation _____ Birth Date _____
Sex: □Male □ Female SS# _____ Tel.# _____
Address _____

HIPAA CONTACT RELEASE FORM

Dear Patient,

In order to help us stay within the guidelines of HIPAA, please list below any Person/persons that you authorize to disclose information to regarding your Protected Health Information, including billing information. (You do not need to list any of your doctors).

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

- **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 or 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 accompanies this Consent. 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:

Contact Person: Ben F. Tarsitano, DDS, MD
Telephone: (831) 722-8887
Fax: (831) 722-2762
Address: 70B Penny Lane, Watsonville, CA 95076

- **Right to Revoke:** You will have the right to revoke this Consent at any time by giving us a 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.

- **Fees & Payments:** Although we accept payments from your insurance company toward your account, you are responsible for you full account. I am aware that they accept Master Card and Visa. I am also aware that my balance must be cleared within three (3) months from the day of treatment. I realize that in the event my account becomes past due and is turned over for collection, I agree to pay the collection fee based on my amount outstanding. This signature on file is my authorization for the release of my information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

SIGNATURE OF GUARANTOR: _____ **Date:** _____

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.

Signature: _____ **Date:** _____

Once you have completed this page, please return it to the front desk.