PATIENT INFORMATION:
Patient Name____
Current Gender Identity: M F Non-binary Other:_________ Sex Assigned at Birth: M F
Date of Birth______________________________ Social Security #_____________________________
Address____
City, State, Zip Code____
Home Phone________________ Cell Phone_________________ Work Phone__________________
Email ____
Employer____
Dentist Preference: _____ Dr. King _____Dr. Carroll _____ No Preference

DENTAL INSURANCE INFORMATION
Primary Insurance____
Group #__________________________________ ID#____
Name of Subscriber______________________________________ Date of Birth__________________
Employer____
PO Box Address to Send Claims to:____
Relationship to Patient: Self ____ Spouse ____ Parent/Guardian ____

PARENT/GUARDIAN INFORMATION (IF APPLICABLE)
Name____
Date of Birth_____________________________ Social Security #_____________________________
Employer____

Payment is expected at the time of service. As a courtesy, we will submit claims on your behalf to the insurance company. We accept cash, check, and credit cards.

____
SIGNATURE of patient and/or guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices from the office of Dr. Liza King & Dr. Patrick Carroll, which sets forth the ways in which my personal health information may be used or disclosed by this office and outlines my rights with respect to such information.

____
Print Name

____
SIGNATURE Date