

DENTAL INSURANCE INFORMATION - Primary

Policy Holder: _____ Relationship to Patient: _____
Address: _____ Date of Birth: _____
_____ Social Security #: _____
Employer: _____ Policy Holder's Phone#: _____
Insurance Company: _____ ID/Subscriber/Contract#: _____
Group#: _____ Insurance Company Phone #: _____

DENTAL INSURANCE INFORMATION - Secondary

Policy Holder: _____ Relationship to Patient: _____
Address: _____ Date of Birth: _____
_____ Social Security #: _____
Employer: _____ Policy Holder's Phone#: _____
Insurance Company: _____ ID/Subscriber/Contract#: _____
Group#: _____ Insurance Company Phone #: _____

Acknowledgement of Receipt of Privacy Rights

I have received a copy of the "Notice of Privacy Practices" (HIPAA Privacy Policy) for Alfred Phen, DDS and Irene Kan, DMD.

Patient or Guardian Signature

Date

I have received a copy of the Dental Board of California's California Department of Consumers Affairs 5/04 the facts about fillings pamphlet.

Patient or Guardian Signature

Date