

Anthony W. Boe D.D.S. P.A., Family Dentistry

ACQUAINTANCE FORM

Patient's name _____ Date of Birth _____

Person Responsible for Payment of Account

Name *(if not patient)* _____ Relationship to patient _____

Address _____
Street City, State ZipCode PO Box

Home phone _____ Bus. _____ Cell _____

Employer _____ Occupation _____

Social Security # _____ Email _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company _____

Subscriber's Name _____ ID# _____

Group Number _____ Insured Birth date _____

Patient's Relationship to subscriber – Self _____ Spouse _____ Child _____

If there is a secondary insurance, please inform the front desk.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

****You may refuse to sign this Acknowledgement****
If refused please ask the front desk to fill out a refusal form.

{Signature}

{Date}

****PLEASE SEE THE NEXT PAGE AND SIGN ALL PLACES NECESSARY****
THANK YOU

MINOR CHILD RELEASE

I give my permission to Dr. Tony Boe and/or his designated staff to perform any and all dental techniques and procedures limited to the administration of nitrous oxide sedation and anesthetics, on my minor child(ren) _____, whether or not I am present at the actual appointment when the treatment is rendered. I further expressly agree to be financially responsible for all treatment rendered to the above named child(ren).

Signed: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: 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 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: Anthony W. Boe DDS
Address: 1880 West Wayzata Blvd. Long Lake, MN 55356-0128
Telephone: (952) 475-0989_Fax: (952)475-2053 Email: info@anthonyboedds.com

Whom may we thank for referring you to us? _____

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 (or my child or person I am responsible for) protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.**

REVOCACTION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____