Clifton E. Nakatani DDS MSD

Practice Limited to Periodontics and Implants

☐ MR. ☐ MRS. ☐ MS. ☐ DR.	LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
HOME ADDRESS		CITY	STATE	ZIP CODE

CELL PHONE	HOME PHONE	WORK PHONE	OTHER PHONE
( )	( )	( )	( )

DRIVER'S LICENSE NO.	SOCIAL SECURITY NO.	EMAIL

OCCUPATION	NAME OF EMPLOYER (OR SCHOOL, IF STUDENT)

BUSINESS ADDRESS	CITY	STATE	ZIP CODE

EMERGENCY CONTACT / RELATIONSHIP TO PATIENT	EMERGENCY CONTACT'S PHONE
	( )

WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?	cc DR.

DENTAL INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE	RELATIONSHIP TO INSURED: ☐ Self ☐ Spouse ☐ Child
NAME OF SECONDARY INSURANCE	RELATIONSHIP TO INSURED: ☐ Self ☐ Spouse ☐ Child

ACKNOWLEDGEMENT & AUTHORITY

I consent to treatment deemed as necessary or desirable to the care of the patient listed above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by Dr. Nakatani or his staff. I authorize Dr. Nakatani and/or his staff to release any medical and/or dental information regarding my dental health to any doctor involved in my treatment.

I hereby authorize the staff of Dr. Nakatani to submit insurance claims for services rendered here today and in the future. I understand that I am responsible for all fees and for payment of all balances not covered by my insurance company. I understand that the above information may be used to obtain credit bureau reports where deemed necessary. I understand that by signing below I acknowledge that should this account be forwarded to a collection agency. I will be responsible for all processing fees incurred.

I have read, understand, and was offered a copy of my right to privacy regarding my protected health information. These rights are given to me under the ***Health Insurance Portability and Accountability Act of 1996 (HIPAA)****. I understand that by signing below I authorize Dr. Nakatani and/or his staff permission to disclose my protected health care information to carry out treatment, obtain insurance payment, and perform day-to-day healthcare operations of the practice.*

I have read, understand, and was offered a copy of the ***Dental Materials Fact Sheet*** *as required by law.*

For your protection, this office will verify your identification ONCE with a valid photo ID (i.e. driver's license or current passport). If the patient is a minor, this office will accept a valid student photo ID or a valid photo ID from the parent/legal guardian. A digital photo will be taken and placed into your account for all future recognition. Should you decline to take a digital photo for your account, the office will make a photocopy of your valid photo ID.

The office may call or text the cell phone(s) listed above regarding treatment, insurance, appointments, and/or my account. The office is also authorized to leave a message if I am not available.

I understand that by signing below I have read and understand all of the above stated paragraphs. I give permission to the Office of Clifton E. Nakatani DDS MSD to discuss any appointment, treatment, and/or finances with the following person(s):

SIGNATURE OF PATIENT (OR GUARDIAN)	DATE