Morris Sussex Oral Surgery Associates, LLC

Kurt Notarnicola, DDS
Board Certified Oral and Maxillofacial Surgeon
Tel: 973-601-0606 Fax: 973-601-1444 www.drkurtnj.com

Patient Information

First Name: _____ Last Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____
Date of Birth: _____ Social Security #: _____
E-mail: _____
Check Appropriate Box: ◊Male ◊Female ◊Minor ◊Single ◊Married ◊Divorced ◊Widowed ◊Separated
Dentist Name: _____

Pharmacy Name and Location: _____

Pharmacy Phone:_____

DENTAL INSURANCE INFORMATION

Policy Holder: _____ Relationship to Patient: _____
Address: _____
City, State, Zip: _____
Date of Birth: _____ Social Security #: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____
Employer: _____
Address of Employer: _____
City, State, Zip: _____
Insurance Company: _____

Policy ID#: _____ Group #: _____

How long have you had this insurance policy for?_____
Does your insurance policy have a waiting period and if so how long?_____

DO YOU HAVE ADDITIONAL INSURANCE? YES NO - IF YES, COMPLETE THE FOLLOWING:

Policy Holder: _____ Relationship to Patient: _____
Address: _____
City, State, Zip: _____
Date of Birth: _____ Social Security #: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____
Employer: _____
Address of Employer: _____
City, State, Zip: _____
Insurance Company: _____
Policy ID#: _____ Group #: _____

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my dentist named above to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released (names of recipients):

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this form.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he or she wishes. Sometimes, state or federal law changes this possibility.

(For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.)

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AND DESCRIBED IN THIS FORM.

Patient signature: _____