

# Welcome To Saini Smiles

Name: \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Current Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Previous Dentist \_\_\_\_\_

How Did You Hear About Us? \_\_\_\_\_

## **In Case of an Emergency Contact**

Name \_\_\_\_\_ Phone# \_\_\_\_\_

Name \_\_\_\_\_ Phone# \_\_\_\_\_

## Notice of Privacy Practices

### Patient Acknowledgment

This Healthcare Practice recognizes that every patient has the right of privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information.

You do not give up any of your Rights and you may choose at some point in the future to provide more specific instructions for us to follow regarding your personal health.

By signing this Acknowledgement: **You are only confirming that you have received a copy of our PRIVACY PRACTICES.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Your Name

## Dental Insurance

**Primary Insurance** \_\_\_\_\_ Phone # \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ Phone # \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_