Michael J. Huber, DDS, MS, PC
Periodontics and Dental Implants

PATIENT DEMOGRAPHIC INFORMATION

Mr. Mrs. Miss Ms. Dr._____
Last First Middle Initial

Name of Spouse/Partner_____

Address _____Apt. No. _____

City, State, Zip _____

Home Phone (____)_____Work Phone (____)_____Ext.#_____

Cell Phone(____) _____ Email Address_____

How do you prefer we contact you? ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Birthdate _____ Social Security # _____-_____-_____

Referred by _____Your General Dentist _____
(If Different from Referral)

DENTAL INSURANCE INFORMATION

Primary Insurance

Name of insured_____

Relationship to Patient_____

Insured's Birthdate _____

Soc. Sec. # _____-_____-_____

Employer_____

Insurance Co. _____

Group # _____

Group Name _____

Secondary Insurance

Name of Insured_____

Relationship of Patient_____

Insured's Birthdate _____

Soc. Sec. #_____-_____-_____

Employer _____

Insurance Co. _____

Group # _____

Group Name _____

___I am not covered by any Dental Insurance at this time

I hereby authorize Michael J Huber, DDS, or his staff to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to Michael J Huber, DDS of the medical and dental benefits otherwise payable to me, for the services rendered to me by either doctors or their staff. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the American Dental Association, and that it is the sole power and responsibility of my carrier(s) to determine the actual dollar amounts of benefits for all services rendered. I understand that I am ultimately responsible for the total costs of my treatment provided by Michael J Huber, DDS.

Privacy of Information Policy: HIPAA - This practice will make reasonable effort to protect the privacy of my health information in accord with the policies set down for dental care providers under the Health Insurance Protection and Accountability Act of 1996 and have read this practice's policy statement on privacy of patient's healthcare information. I authorize the release any and all medical and dental information pertinent to my treatment to my other treating healthcare providers. By signing below, I agree that I have been informed.

I acknowledge that I have read and understand the above statements and policies and that this authorization remains valid and effective from the date of signing until revoked in writing.

_____ _____
Signature of Patient or Patient's Legal Guardian Date of Signature