168 U.S. Route 1, Falmouth ME 04105
Robert Nelson DDS

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:
Is this your legal name? Yes☐ No☐	Nickname:	
DOB: Age: Sex M☐ F☐	SSN: (If APS files claims to your insurance company)	
Street Address: City: State: Zip Code:		
Best Number to Reach You: Cell☐ Home☐ Work☐		
E-mail address:		
How would you like to be reminded of appointments? Text☐ Email ☐ Call☐		
Who may we thank for referring you?	Other Family members seen here:	

In Case of Emergency

Name:	Relationship to Patient:	Ph#

RESPONSIBLE PARTY (i.e. if patient is minor)

Last Name:	First Name:	Middle Initial:

INSURANCE INFORMATION

Insurance Company Name:	Group #	ID#
Insurance Company Ph#:	Policyholder Name:	
Policyholder SSN:	Policyholder DOB:	
Patient Relationship to Policy Holder: Self ☐ Spouse☐ Child☐ Other ☐		
Employer:	Employer Address:	

Acknowledgement to Receive Notice of Privacy Practices

In accordance with the privacy law under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, our office must take reasonable steps to limit the use of disclosure of, and requests for, your protected health information. Under this law we are also required to provide you access to our privacy practices, which details how health information about you may be used and how you may access this information.

We ask that you sign below to acknowledge that you have been made aware that you may request a copy of our privacy practices at any time.

_____ _____

Signature Date