

**Leslie B. Anthony, D.M.D., P.C.**  
**75 Claremont Street, Suite G, Northwest Professional Building**  
**Kalispell, Montana 59901**  
**(406) 752-8161 Fax: (406) 752-8090**

**PATIENT INFORMATION**

Date of First Visit/Information \_\_\_\_\_

NAME \_\_\_\_\_ Married \_\_\_ Single \_\_\_ Minor \_\_\_ Male \_\_\_ Female  
 Last First MI  
 ADDRESS: \_\_\_\_\_  
 Street Apt.# City State Zip  
 MAILING ADDRESS \_\_\_\_\_  
 (If different than above) Street Apt.# City State Zip  
 BIRTHDATE \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
 Month Day Year Home # Cell # Work #  
 EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_ SOC.SEC.# \_\_\_\_\_

**BILLING/RESPONSIBLE PARTY INFORMATION**

(Complete if different than patient information above.)

Name: \_\_\_\_\_ Relationship: Self \_\_\_ Parent \_\_\_ Spouse \_\_\_ Guardian \_\_\_ Other \_\_\_  
 Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Street Apt. # City State Zip  
 Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
 Position: \_\_\_\_\_ No. of Yrs. Employed: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Spouse's Soc. Sec. # \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ No. of Yrs. Employed: \_\_\_\_\_ Business Phone: \_\_\_\_\_

**EMERGENCY CONTACT PERSON**  
**Outside of Immediate Family Household**

Whom may we Thank for referring you to our office?

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Telephone: \_\_\_\_\_

\_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE**

**Health Insurance Portability & Accountability Act**

We are required by applicable Federal and State law to maintain privacy of your health information. We are also required to give you notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy policies as described in our *Privacy Practices Notice* while it is in effect. This notice took effect on April 15, 2003, and will remain in effect until we replace it. We use and disclose health information about you for treatment, payment and healthcare operations. Specific information and explanation is provided with the Notice. If you want more information about our privacy practices or have questions or concerns, please contact us.

We support your right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U S Department of Health and Human Services.

With signature hereon, I acknowledge receipt of a copy of the *Notice of Privacy Practices of Leslie B. Anthony, D.M.D., P.C.*

I, \_\_\_\_\_, have received a copy of this offices' *Notice of Privacy Practices*.

\*\*You may refuse to sign this Acknowledgement.

**INFORMED CONSENT FOR DENTAL TREATMENT**

I understand there are rare complications and/or side effects to any dental treatment that I might receive including but not limited to : the occurrence of a hematoma, trismus and parathesia.

In addition, there may be ; 1). pain, swelling, inflammation or infection of the area of the injection of local anesthesia, 2). Injury to nerves or blood vessels in the area. 3). An allergic or unexpected reaction to materials and/or medications,

Fortunately, these complications and side effects are not common. Most dental treatment is generally very safe, comfortable and well-tolerated.

I have read and understand the above risks and give my consent for dental treatment. I have given complete and truthful medical history, including all medications, drug use, pregnancy, etc. I certify that I speak, read and write the English language.

\_\_\_\_\_  
 Patient's (or Legal Guardian's) Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Representative for Dr. Leslie B. Anthony, D.M.D., PC

\_\_\_\_\_  
 Date