

Timothy T. Hopkins DDS, MS

590 Falls Ave  
Twin Falls, ID 83301

*Patient Information:*

**Patient Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_ **Age** \_\_\_ **Sex** \_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_ Zip \_\_\_\_\_  
(Physical Address)

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_ Zip \_\_\_\_\_  
(Mailing Address- if different from above)

SSN \_\_\_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Home Phone# \_\_\_\_\_ Alternate Phone# \_\_\_\_\_

Patient Employer \_\_\_\_\_ Work Phone# \_\_\_\_\_

Referring Doctor \_\_\_\_\_ General Family Doctor \_\_\_\_\_

**Spouse Name** \_\_\_\_\_ **Phone#** \_\_\_\_\_ **Employer** \_\_\_\_\_

**Parent Name** \_\_\_\_\_ **Phone#** \_\_\_\_\_ **Employer** \_\_\_\_\_  
(Father)

**Parent Name** \_\_\_\_\_ **Phone#** \_\_\_\_\_ **Employer** \_\_\_\_\_  
(Mother)

**Emergency contact** \_\_\_\_\_ **Ph#** \_\_\_\_\_ **Relation** \_\_\_\_\_  
(Not in household)

*Was this an injury or an accident at work?*

Work Injury: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ How did Accident Happen? \_\_\_\_\_

Other Accident: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Where: \_\_\_\_\_

*Insurance Information:*

**Dental Insurance** \_\_\_\_\_  
\*please provide card to receptionist for copy\*

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ Relation to patient \_\_\_\_\_

SSN/Policy# \_\_\_\_\_ Employer/Group \_\_\_\_\_

**Medical Insurance** \_\_\_\_\_  
\*please provide card to receptionist for copy\*

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ Relation to patient \_\_\_\_\_

SSN/Policy# \_\_\_\_\_ Employer/Group \_\_\_\_\_

I authorize other health care providers to release my medical records to Dr. Tim Hopkins. I authorize the release of medical information to Medicare/ Other Third Party Payors. I authorize evaluation and treatment by Dr. Tim Hopkins. I authorize payment of medical/dental benefits to Dr. Tim Hopkins. I permit a copy of this authorization to be used in place of the original. I request that payment of authorized Medicare/Medigap benefits be made either to me or on my behalf to Dr. Tim Hopkins for any services furnished me by that physician. I authorize any holder of medical information about me to release it to Health Care Financing Administration/Medigap and its agents, any information needed to determine these benefits or the benefits payable for related services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_