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___

Phone#_____ **Pharmacy:** _____

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:_____