

PATIENT REGISTRATION

PATIENT INFORMATION

Date: _____

Patient Name: _____
First Last Middle Initial

Preferred Name: _____

Patient Is: Policy Holder Responsible Party
 Full Time Student

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: (____) ____ - ____ Cellular: (____) ____ - ____

Work Phone: (____) ____ - ____ Ext: _____

I would like to receive correspondences via text.

Email: _____

I would like to receive correspondences via email.

Please indicate the best way the reach you.

Married Widowed Single Minor

Separated Divorced Other

Birth Date: _____ Age: _____

Soc. Sec. #: _____

Drivers Lic: _____

Sex: Male Female

Patient Employer: _____

Spouse's Name: _____

Spouse's Phone #: (____) ____ - ____

Spouse's Email: _____

In case of Emergency, contact:

Name: _____

Relationship: _____

Daytime Phone: (____) ____ - ____

Whom may we thank for referring you?

RESPONSIBLE PARTY INFORMATION

(if different from patient)

Name: _____
First Last Middle Initial

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: (____) ____ - ____ Cellular: (____) ____ - ____

Work Phone: (____) ____ - ____ Ext: _____

Birth Date: _____ Age: _____

Soc. Sec. #: _____

Drivers Lic.: _____

DENTAL INSURANCE

Policy Holder's Name: _____

Relationship to Patient: _____

Birth Date: _____ Soc. Sec. #: _____

Employer: _____

Insurance Co.: _____

Group #: _____

Member ID: _____

Is Patient covered by additional insurance? Yes No

Secondary Insurance Co.: _____

Policy Holder's Name: _____

Relationship to Patient: _____

Birth Date: _____ Soc. Sec. #: _____

Employer: _____

Group #: _____

Member ID: _____

Assignment and Release for Insurance

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

HIPAA

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I have received a copy of the Notice of Privacy Practice (HIPAA).

 Signature of Patient, Parent, Guardian or Personal Representative

 Please Print name of Patient, Parent, Guardian or Personal Representative

 Date

 Relationship to Patient

