PATIENT REGISTRATION

Patient Information:

Patient's name: ______________________________

Mailing address: ______________________________

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Patient's employer: ______________________________

Occupation: ________________ Social Security: ____________________

Status: Single Married Divorced Widowed

DOB: ________________ Sex: Male Female

Home #: ________________________

Work #: ________________________

Cell #: ________________________

Email: ________________________

Please check box of your preferred confirmation method.

*If you want text reminders, please list your cell phone carrier:

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How did you hear about this office______________________________

Emergency Contact: ______________________________ Phone: ____________________

Account Information: (who is responsible for this account, if different than patient)

Account holder's name: ______________________________

Relationship to patient: ______________________________

Mailing address: ______________________________

Home #: ________________________ Work #: ________________________ Cell #: ________________________

Email: ________________________ Social Security #: ________________ DOB: ________________________

Dental Insurance Information:

Subscriber's name: ______________________________ DOB: ________________________

Subscriber's employer: ______________________________ Insurance ID#: ____________________

Insurance Carrier: ______________________________ Group #: ____________________

Insurance address: ______________________________ Phone: ____________________

Patient's relationship to subscriber: ______________________________

Please read and sign below to acknowledge your HIPPA rights:
I understand that my privacy is protected under the HIPAA guidelines. I have been offered a copy of the HIPAA guidelines to review and/or have, and I am aware that the Notice of Privacy Practices is posted in the reception room.

Patient's signature: ______________________________ Date: ________________________
Guardian's signature if patient under 18

Please read and sign below for AUTHORIZATION, RELEASE and AGREEMENT TO PAY SERVICES
I hereby authorize the Doctor and/or staff to perform treatment mutually agreed upon by me. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks and I can ask for a complete recital of any possible complications. I authorize the release of any information and/or records rendered to me to other healthcare professionals and/or insurance companies when necessary to aid in my diagnosis and/or treatment. I hereby authorize my dental insurance carrier to pay directly to my dental provider for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of insurance coverage. I understand that payment is due at the time of service unless prior arrangements have been made. I agree to pay a late charge on overdue account balances, if applicable. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees in attempting to collect the balance on the account.

Patient's signature: ______________________________ Date: ________________________
Guardian's signature if patient under 18