PATIENT REGISTRATION

Patient Name:
First_____ Last_____Preferred_____

Address:_____
Street City State Zip

Phone (Home)_____(Work)_____(Cell)_____

Date of Birth_____SSN _____ Employer_____

INSURANCE INFORMATION

Insured's name_____ Relationship_____

Employer_____ Policy Number_____

Date of Birth _____ Insured's SSN _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

Name_____ Phone _____

Address_____ SSN_____

Date of Birth_____ Relationship_____

Emergency Contact and Phone #_____

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and records of any treatment or examinations during the period of such dental care to third party payers (insurance) and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand I am responsible for payment of all services rendered on my behalf or my dependents. By providing us with your cell number, you are hereby granting us, and our agents or independent contractors your consent to receive calls on your cell phone. If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed may be assessed each month. I realize that failure to keep this account current may result in this office not being able to provide additional dental services except for dental emergencies or where there is prepayment for services. In case of default of this account I agree to pay collection costs and reasonable attorney fees incurred in an attempt to collect debt. I have read and understand the above and that all information is accurate.

Signature_____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

_____ _____
PATIENTS PRINTED NAME PATIENTS SIGNATURE DATE

_____
SIGNATURE OF PERSONAL RESPRESENTATIVE DATE