PATIENT ACCOUNT REGISTRATION

PAYMENT BY: CASH _____ INSURANCE: _____ TITLE 19/HMO _____

PATIENT'S

NAME _____
Last First Initial

IF CHILD:

PARENT'S NAME _____
Last First Initial

Date of Birth _____ SEX M ❑ F ❑

Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

ADDRESS _____

CITY _____ STATE ____ ZIP _____

TELEPHONE: HOME ( ) _____ WORK ( ) _____

CELL ( ) _____ EMAIL _____

PATIENT/PARENT EMPLOYED BY _____

BUSINESS ADDRESS _____

PRESENT POSITION _____ HOW LONG HELD _____

SPOUSE/PARENT NAME _____

SPOUSE EMPLOYED BY _____

OTHER FAMILY MEMBERS IN THE PRACTICE _____

_____

PATIENT/PARENT SOCIAL SECURITY NO. _____

SPOUSE/PARENT SOCIAL SECURITY NO. _____

HOW DID YOU HEAR ABOUT US:

❑ REFERRAL
❑ YELLOW PAGES
❑ DENTAL PROTECTION PLAN
❑ INSURANCE COMPANY
❑ NEWSPAPER

DENTAL INSURANCE (PRIMARY)

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ #YRS _____

NAME OF INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE _____

GROUP OR POLICY # _____

SOCIAL SECURITY NO. _____

DENTAL INSURANCE PRIMARY (ADDITIONAL)

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ #YRS _____

NAME OF INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE _____

GROUP OR POLICY # _____

SOCIAL SECURITY NO. _____

MEDICAL INSURANCE

EMPLOYEE NAME _____

NAME OF INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE _____

PROGRAM OR POLICY # _____

GROUP _____

WHOM MAY WE THANK FOR THIS REFERRAL _____

NOTIFY IN CASE OF EMERGENCY _____ TELEPHONE _____

TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and heathcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less that the actual bill of services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole or in part by my dental care payor.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____