PATIENT REGISTRATION

NAME (LAST, FIRST, MIDDLE) (NICKNAME) | DATE OF BIRTH | PRESENT AGE | S M D W C

ADDRESS | CITY | STATE/PROV. | ZIP/P.C.

HOME PHONE | CELL PHONE

SS #/SIN | E-MAIL

EMPLOYER | OCCUPATION

ADDRESS

PERSON RESPONSIBLE FOR ACCOUNT

NAME | RELATIONSHIP

ADDRESS

SS #/SIN | E-MAIL

EMPLOYER | OCCUPATION

ADDRESS

INSURANCE INFORMATION

INSURANCE COMPANY

NAME OF GROUP DENTAL PROGRAM

POLICY NUMBER | GROUP NUMBER

UNION LOCAL

EFFECTIVE DATE OF INSURANCE | TIME LIMIT FOR CLAIMS

METHOD OF PAYMENT ☐ UCR ☐ SCHEDULE OF BENEFITS ☐ OTHER

CO-INSURANCE: INSURANCE CO. SHARE | PATIENT'S SHARE

DEDUCTIBLE: ☐ YES ☐ NO $ _____ AMOUNT

IF YES: ☐ INDIVIDUAL ☐ FAMILY ☐ ANNUAL ☐ LIFETIME

COVERAGE

EXCLUSIONS ☐ PROPHYLAXIS ☐ ORTHODONTICS

☐ OTHER

STANDARD FORM ACCEPTED? ☐ YES ☐ NO

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

FAMILY PHYSICIAN | MEDICAL ALERT

NEAREST RELATIVE

PHONE

ADDRESS

CREDIT REFERENCES

BANK

CHECKING ACCOUNT NO.

CREDIT CARD (S)

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature | Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentists or dental entity.

X _____
Subscriber signature | Date

RELATIONSHIP | BIRTHDATE

Privacy Practices Documentation

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name _____ (Please Print) Birthdate _____

Signature _____ Date _____

---------- To Be Completed by Front Office ----------

Written acknowledgement could not be documented due to:

- ☐ Patient refused to sign
- ☐ Personal representative not available to sign
- ☐ Language, communication, or effects of disability impeded acknowledgement
- ☐ Emergency care impeded acknowledgement
- ☐ Other, please specify _____

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PATIENT REGISTRATION

PATIENT NAME _____