PATIENT REGISTRATION

NAME_____

LAST FIRST MIDDLE (NICKNAME)

ADDRESS_____

CITY_____STATE_____ZIP CODE_____

HOME PHONE_____CELL PHONE_____

WORK PHONE_____EMPLOYER_____

SS#___ __- - _____DATE OF BIRTH____/_____/_____PRESENT AGE_____S M D W C__

E-MAIL_____

Would you like to receive notifications via e-mail or text? Email Text

EMERGENCY CONTACT INFORMATION

FAMILY PHYSICAN_____

NEAREST RELATIVE_____PHONE NUMBER_____

PERSON RESPONSIBLE FOR ACCOUNT

NAME_____RELATIONSHIP_____

DENTAL BENEFIT INFORMATION

DENTAL INSURANCE COMPANY_____GROUP#_____

Having 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

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Daniel A. Nosal, DMD.

X_____

Subscriber signature Date

PRIVACY PRACTICES DOCUMENTATION

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

PATIENT NAME_____BIRTH DATE_____

(Please Print)_

SIGNATURE_____DATE_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____