PATIENT REGISTRATION

Patient Information

First Name: ______________________________ Last Name: ______________________________

Preferred Name (If different than above): ______________________________

Address: ____

City: ______________________ State / Zip Code: _______ / ____________

Birth Date: _______/________/________ Social Security Number: ___________________ Sex: ☐ Male ☐ Female

Cell Phone: (______) ________________________ Home Phone: (______) ________________________
(Text messages will be sent to confirm appointments- opt out options are available)

Email: ______________________________________ Work Phone: (______) ________________________
(E-mail messages will be sent to confirm appointments and/or office promotions- opt out options are available) Ext: _________

Preferred Pharmacy: ______________________________

Emergency Contact: ______________________ Relationship: _______________ Phone: (______) ___________________

Patient History

Last Dental Visit: ______________________ Previous Dentist: ______________________

How did you hear about our office? If you were referred by one of our patients, please write their name so we can thank them.____________
____

Responsible Party (If patient is under 18 years old)

First Name: ______________________________ Last Name: ______________________________

Address: ____

City: ______________________ State / Zip Code: _______ / ____________

Cell Phone: ____________________ Home Phone: ____________________ Work Phone: ____________________ Ext: _________

Birth Date: _______/________/________ Social Security Number: ___________________

PATIENT DISCLOSURE INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The individual's health information will be made available to referred specialists for the individual's advised treatment.

I allow you to give my clinical information to and answer questions from (*check all that apply)*:

PLEASE LIST NAME AND PHONE NUMBER

- ☐ Spouse: ____
- ☐ Parent(s): ____
- ☐ Other (specify): ____
- ☐ None

______________________________ _____/_____/______ ______________________________
Patient (or Guardian) Signature Date Print Name