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: ______________

Birth Date: ______/______/______ Social Security Number: ______________ Ext: ________

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