PATIENT REGISTRATION

Your Name: (last)___________________________________(first)__________________________(m initial)_____(DOB)_________________

Address:____City:___________________________State:______Zip:________________

Phone:____________________________________Work:__________________________________Cell:_______________________________

Status: Married Single Social Security #:___________________________________ Sex: Male Female

Preferred Name:______________________________ E-mail:___________________@____________ Employer:________________________

RESPONSIBLE PARTY

Name: (last)_______________________________________(first)____________________(m initial)_____Relationship:__________________

Address:____City:___________________________State:______Zip:_________________

Social Security #:_________________________Phone:____________________Work_____________________Cell____________________

GETTING TO KNOW YOU

Is another member of your family a patient?____

Emergency contact person:____Phone_____________________________________

How did you hear about us: Friend/family Website Phone book Radio ad TV ad Newsletter Newspaper

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of ____________________________'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
2. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
3. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notices of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my restriction, but if you do agree, then you are bound to abide by such restrictions.

Patient's Signature:____Date:_______________________Witness:_________________________

Responsible Party's Signaure:____Relationship:________________________________