DAURITY

FAMILY DENTISTRY

Patient Registration

First Name: _____Middle Initial: _____ Last Name: _____

Address: _____Home Phone: (___) _____-_____

City: _____State: _____Zip: _____ Work Phone: (___) _____-_____

Birth Date: _____/_____/_____ Age: _____ Cell Phone: (___) _____-_____

Sex: Male/Female Marital Status: Married/Single/Widow SSN: _____-___-_____

Email Address: _____

Emergency Contact: _____Phone: (___) _____-_____

Preferred method of contact: Phone Call/Text/Email

How did you hear about our office? _____

Is there anyone we can thank for referring you? _____

Dental Insurance Information

Subscriber: _____Date of Birth: _____/_____/_____

Subscriber SSN: _____-_____-_____ Employer: _____

Business Phone: (___) _____-_____ Insurance Company: _____

Insurance Phone: (___) _____-_____ Group Number: _____

Patient ID: _____ Relationship to subscriber: _____

Responsible Party (if other than patient)

Name: _____ Date of Birth: _____/_____/_____

Address: _____SSN:_____-____-_____

_____Relationship to patient:_____

Home Phone: (___) _____-_____ Work Phone: (___) _____-_____Cell Phone: (___) _____-_____

Regarding HIPAA

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you information about our privacy practices. By signing below, you are acknowledging you have reviewed a copy of our HIPAA privacy handout.

Signature: _____Date:_____/_____/_____