



PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: Policy Holder Preferred Name: _____
 Responsible Party Preferred Pharmacy: _____ Phone: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

Email: _____ I would like to receive correspondences via email

Employment Status: Full Time Part Time Retired

How did you hear about our office?

Student Status: Full Time Part Time

Website TV Yellow Pages

EMERG CONTACT: _____

Google Friend _____

Relationship to Patient: _____

Doctor _____

Phone number: _____

Other _____

Responsible Party (if someone other than patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Primary Insurance Information

Name of Policy Holder: _____ Relationship to patient: Self Spouse Child Other

Policy Holders Soc Sec: _____ Policy Holders Birth Date: _____

Policy Holders Employer: _____

Employer Address: _____ City, State, Zip: _____

Insurance Company: _____ Phone Number: _____

Address: _____ City, State, Zip: _____

Secondary Insurance Information

Name of Policy Holder: _____ Relationship to patient: Self Spouse Child Other

Policy Holders Soc Sec: _____ Policy Holders Birth Date: _____

Policy Holders Employer: _____

Employer Address: _____ City, State, Zip: _____

Insurance Company: _____ Phone Number: _____

Address: _____ City, State, Zip: _____



Concept Dental
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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to my 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
- ✦ Obtain payment from third-party payers for my health care services
- ✦ 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 *Notice 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 at the address above to obtain a current copy of the *Notice of Privacy Policy*.

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 requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

- ✦ I give my permission to the above provider to leave messages at my contact phone numbers regarding appointments and treatment, with the following exceptions _____

Patient Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

FOR OFFICE USE ONLY:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign Communication barriers Emergency situation
 Other _____