

Patient Registration

This is a proprietary document. All information contained herein will be held in strict confidence.

PATIENT INFORMATION

Name			Parent / Legal Guardian		
First	Middle	Last	First	Last	
Address				Driver license #	
Street Address		City	State	ZIP	
Date of birth / /		Social security number - -		Gender MALE FEMALE	
Primary phone () -		Alternate phone () -		Contact preferences Check all that apply Text Email Automated call	
Email					

EMERGENCY CONTACT

Name		Relationship	Primary phone () -
First	Last		
Address			Alternate phone () -
Street Address		City	State ZIP

EMPLOYMENT

Patient's place of employment	Spouse/Partner/Parent's place of employment
Employer address	Employer address
Street address	Street address
City State Zip	City State Zip
Patient's work phone () -	Spouse/Partner/Parent's work phone () -
May we call you at work? YES NO	May we contact your spouse/partner/parent at work? YES NO

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INSURANCE

PRIMARY COVERAGE			SECONDARY COVERAGE		
SELF	SPOUSE/PARTNER	PARENT	SELF	SPOUSE/PARTNER	PARENT
Subscriber name			Subscriber name		
First	Last		First	Last	
Social security number	Date of birth		Social security number	Date of birth	
- -	/ /		- -	/ /	
Insurance company			Insurance company		
Policy/ID number	Group Number		Policy/ID number	Group number	
Insurance carrier address			Insurance carrier address		
Street address			Street address		
City	State	Zip	City	State	Zip
Insurance carrier phone			Insurance carrier phone		
() -			() -		

HOW DID YOU HEAR ABOUT REFLECTIONS DENTAL CENTRE?

Friend or family member: _____	Walked past office before
A social feed (e.g. Facebook, Twitter, Google+, etc.)	Physician Referral
Searching on the internet	Other: _____

RELEASE

Assignment of Benefits and Release of Information

By my signature, I hereby acknowledge my responsibility to pay for services rendered to me and I authorize the release of any information required for payment or review of a dental claim except as prohibited by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I authorize that my insurance benefits be paid directly to the dentist and I understand that I am financially responsible for the cost of any and all services rendered to me or to my dependent children regardless of insurance coverage.

Signed: _____
 Signature of patient (or parent/legal guardian)

Date signed: _____