PATIENT REGISTRATION

Date: _____

Name: _____

(Last Name) (First Name) (Middle Initial)

Preferred Name: _____

Date of Last Dental Exam: _____ Marital Status: _____

Birthdate: _____ Social Security No.: _____

Address: _____ Apartment/Unit No.: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____

Employed By: _____ Occupation: _____

Work Phone: _____

Spouse Name or Parent if Minor: _____ Birthdate: _____

Phone Number: _____ Social Security No.: _____

Employed By: _____ Occupation: _____

Dental Insurance Company: _____

Address/Phone: _____

Subscriber: _____ ID No.: _____ Group No.: _____

Notify in Case of Emergency: _____ Phone No.: _____

Who may we thank for referring you? _____

Mandatory Consent: I acknowledge that I have received a copy of Saving Smiles Dentistry's Privacy Practices. This notice describes how Saving Smiles Dentistry may use and disclose my health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

Signature: _____ Date: _____