PATIENT REGISTRATION

Last Name _____ First _____ Initial _____ Mr. Mrs. Ms. Dr. Rev.

Date of Birth _____ Gender_____ Preferred Name _____

❑ Single ❑ Married ❑ Widowed ❑ Other Email Address_____

Address_____City_____State_____Zip _____

Telephone (Mobile) _____ (Home) _____ (Work) _____

Employer_____ SS# ____-___-_____ How did you hear about our practice? _____

Spouse Name _____ Date of Birth _____ Mobile# _____

PRIMARY DENTAL INSURANCE *******	SECONDARY DENTAL INSURANCE
Subscriber Name_____	Subscriber Name_____
Subscriber Social Security#_____	Subscriber Social Security#_____
Subscriber Date of Birth _____	Subscriber Date of Birth _____
Your relationship to Subscriber:	Your relationship to Subscriber:
❑ Self ❑ Spouse ❑ Child ❑ Other	❑ Self ❑ Spouse ❑ Child ❑ Other
Employer Name_____	Employer Name_____
Insurance Company_____	Insurance Company_____
Insurance Group #_____	Insurance Group #_____
Subscriber ID#_____	Subscriber ID#_____

RESPONSIBLE PERSON FOR THIS PATIENT (Complete if someone other than yourself)

Last Name_____First_____Initial:_____ Date of Birth_____

Address *(If different)*_____ City_____State_____Zip_____

Telephone (Mobile)_____(Home)_____Email_____

EMERGENCY CONTACT Name_____ (Mobile)_____(Home)_____

AUTHORIZATION I consent to the diagnostic procedures and dental treatment performed by Dr. Paper or designated staff, and to the release of information concerning my health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to Dr. Paper, and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance. If in the event my account balance is forwarded to a collection agency I will be responsible for all cost incurred in the collection process; Including agency fees, attorney fees and court cost.

***ELECTRONIC COMMUNICATIONS*:** I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails, or by replying STOP via text.

Print Name _____Signature _____ Date _____

DENTAL HISTORY

Reason for today's visit_____

Former dentist_____**Phone number**_____

Date of last dental visit_____ **Last x-rays**_____

How many times a day do you brush_____ and you use a: ❑ Manual brush ❑ Electric brush ❑ Sonic brush ❑ Spin brush

How often do you floss? _____ Do you get any bleeding when you brush?_____