Welcome to First Dental Center

Please Complete the Following Confidential Patient Registration Information

Patient Name _____ (First MI Last) Name you prefer to be called: _____

Home Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell _____

Birthdate _____ Please Circle Male Female

Social Security # _____ Single Married Divorced Widowed Other

Whom may we Thank for Referring You? _____ Spouse's Name _____

Person to Contact in Case of Emergency? _____ Contact Phone _____

Please Complete the Following Confidential Contact Information

Email Address _____

Please circle your contact preference: Home Ph. (call,voicemail) Cell Ph (call,voicemail) Email Text

Please indicate any Person with whom you give us permission to discuss your Dental Treatment, Appointments, or Fees:

Name _____ Phone _____ Relation _____

If you Have Dental Insurance, Please Complete the Following Information

Name of Insured _____ Relationship to Patient _____

Social Security or ID # of Insured _____ Birthdate of Insured _____

Employer or Group Name _____ Group Number _____

Insurance Company Name _____ Insurance Phone # _____

****If you have coverage with more than one Dental Insurance Company, Please let us know.****

Please read and sign below to acknowledge your HIPAA rights

My signature below indicates that I have been informed of my rights to privacy regarding my personal health information under the Health Insurance Portability & Accountability Act of 1996(HIPAA). I acknowledge that I have been offered a copy of the Federal HIPAA guidelines.

Printed Name _____ Date _____

Signature _____

Please read and sign below for Authorization, Release, and Agreement to Pay for Services

I hereby authorize the Doctor and/or staff to perform treatment mutually agreed upon by me. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks and I can ask for a complete recital of any possible complications. I authorize the release of any information and/or records rendered to me to other healthcare professionals and/or insurance companies when necessary to aid in my diagnosis and/or treatment. I hereby authorize my dental insurance carrier to pay directly to my dental provider for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of insurance coverage. I understand that payment is due at the time of service unless prior arrangements have been made. I agree to pay a billing fee, if balance is not paid within 35 days of the monthly billing date. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees in attempting to collect the balance on the account. I authorize this office to leave messages and/or mail correspondence to remind me of upcoming appointments. I understand that a broken appointment fee of $35.00 may be charged to my account if I miss an appointment or cancel with less than 48 hours notice.

Signature _____ Date _____