DAURITY
FAMILY DENTISTRY

Patient Registration

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ Home Phone: (____) _____-_____
City: _____ State: _____ Zip: _____ Work Phone: (____) _____-_____
Birth Date: _____/_____/_____ Age: _____ Sex: Male/Female Cell Phone: (____) _____-_____
Marital Status: Married/Single/Widow Occupation: _____ SSN: _____-_____-_____
Email Address: _____ Preferred contact method: Call/Text/E-mail
Emergency Contact: _____ Phone: (____) _____-_____
How did you hear about our office? _____
Is there anyone we can thank for referring you? _____

Dental Insurance Information

Subscriber: _____ Date of Birth: _____/_____/_____
Subscriber SSN: _____-_____-_____ Relationship to subscriber: _____
Employer: _____ Business Phone: (____) _____-_____
Insurance Company: _____ Insurance Phone: (____) _____-_____
Group Number: _____ Patient ID: _____

Responsible Party (if other than patient)

Name: _____ Date of Birth: _____/_____/_____
Address: _____ SSN:_____-_____-_____
_____ Relationship to patient:_____
Home Phone: (____) _____-_____ Work Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Regarding HIPAA

We will not discuss you protected health information unless authorized by you. If you would like us to discuss your treatment or account with anyone else please provide the person(s) name and relationship to you below.

Name: _____ Relationship: _____
Name: _____ Relationship: _____

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you information about our privacy practices. By signing below, you are acknowledging you have had a chance to review a copy of our HIPAA privacy handout.

Signature: _____ Date: _____/_____/_____