PATIENT ACCOUNT REGISTRATION

PAYMENT BY: CASH _______ INSURANCE _______ TITLE 19/HMO _______

PATIENT'S
NAME ______________________
Last First Initial

IF CHILD:
PARENT'S NAME ______________________
Last First Initial

Date of Birth __________ SEX M ❑ F ❑

Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

ADDRESS ______________________

CITY __________ STATE _____ ZIP _______

TELEPHONE: HOME ( ) _______ WORK ( ) _______

CELL ( ) __________ EMAIL __________

PATIENT/PARENT EMPLOYED BY __________

BUSINESS ADDRESS __________

PRESENT POSITION __________ HOW LONG HELD _______

SPOUSE/PARENT NAME __________

SPOUSE EMPLOYED BY __________

OTHER FAMILY MEMBERS IN THE PRACTICE __________

____

PATIENT/PARENT SOCIAL SECURITY NO. __________

SPOUSE/PARENT SOCIAL SECURITY NO. __________

HOW DID YOU HEAR ABOUT US:

- ❑ REFERRAL
- ❑ INSURANCE CO.
- ❑ YELLOW PAGES
- ❑ NEWSPAPER
- ❑ DENTAL PROTECTION PLAN

DENTAL INSURANCE (PRIMARY)

EMPLOYEE NAME __________

EMPLOYEE DATE OF BIRTH __________

EMPLOYER __________ #YRS _______

NAME OF INSURANCE CO. __________

ADDRESS __________

____

TELEPHONE __________

GROUP OR POLICY # __________

SOCIAL SECURITY NO. __________

DENTAL INSURANCE (ADDITIONAL)

EMPLOYEE NAME __________

EMPLOYEE DATE OF BIRTH __________

EMPLOYER __________ #YRS _______

NAME OF INSURANCE CO. __________

ADDRESS __________

____

TELEPHONE __________

GROUP OR POLICY # __________

SOCIAL SECURITY NO. __________

MEDICAL INSURANCE

EMPLOYEE NAME __________

NAME OF INSURANCE CO. __________

ADDRESS __________

____

TELEPHONE __________

PROGRAM OR POLICY # __________

GROUP __________

WHOM MAY WE THANK FOR THIS REFERRAL ______________________

NOTIFY IN CASE OF EMERGENCY __________ TELEPHONE __________

TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill of services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole or in part by my dental care payor.

PATIENT'S OR GUARDIAN'S SIGNATURE: ______________________ DATE __________

BAY VIEW DENTAL CARE