PATIENT REGISTRATION

Patient Information:

First Name:_____ Middle Initial:____

Last Name:_____ Birthdate:_____

Preferred Name:_____ Social Security#_____

Address:

Street:_____ Apt# or PO Box:_____

City, State, Zip:_____

Sex: ○ Female ○ Male ***Marital Status:*** ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

****PLEASE PROVIDE AT LEAST 2 METHODS OF CONTACT***

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-mail:_____

□ I would like to receive email correspondences and appointment confirmations

□ I would like to receive a text message for appointment confirmations

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Collegiate Student Status: ○Full Time ○ Part Time

Preferred Dentist: Preferred Hygienist: Preferred Pharmacy:

- ***Whom may we thank for referring you to our practice?_____***

- **Previous Dentist Name and Address: _____**
  Date of Last Dental Exam:_____ Date of Last Dental Cleaning:_____

Responsible Party: (if someone other than the patient)

First Name:_____ Middle Initial:____

Last Name:_____ Birthdate:_____

Preferred Name:_____ Social Security#_____

Address:

Street:_____ Apt# or PO Box:_____

City, State, Zip:_____

Sex: ○ Female ○ Male ***Marital Status:*** ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Primary Insurance Information:

Name of Insured:_____ ***Relationship to Insured***: ○Self ○Spouse ○Child ○ Other

Insured Social Security # or Member ID #: _____ Insured Birth date:_____

Employer Name: _____ Occupation: _____

Employer Address:_____ Suite # or PO Box:_____

City, State, Zip:_____

Insurance Company Name: _____ Group# _____

Insurance Co. Address:_____ Suite # or PO Box:_____

City, State, Zip:_____

***** Do you have any additional insurance? __ Yes __No (If yes, complete the following)***

Secondary Insurance Information:

Name of Insured:_____ ***Relationship to Insured***: ○Self ○Spouse ○Child ○ Other

Insured Social Security # or Member ID #: _____ Insured Birth date:_____

Employer Name: _____ Occupation: _____

Employer Address:_____ Suite # or PO Box:_____

City, State, Zip:_____

Insurance Company Name: _____ Group# _____

Insurance Co. Address:_____ Suite # or PO Box:_____

City, State, Zip:_____

PATIENT DISCLOSURE INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The individual's health information will be made available to referred specialists for the individual's advised treatment.

I authorize Darby Creek Dental to disclose my clinical information to answer questions from (check all that apply):

*****Please list name of person(s)***

☐ Spouse: _____ ☐ Other (specify):_____

☐ Parent (s): _____ ☐ None

_____

Patient (or Guardian) Signature Date Print Name