PATIENT REGISTRATION

ELK DENTAL CENTER

Patient Name (inc. Middle Initial) _____ Date of Birth _____

Nickname _____ Social Security Number _____ Gender ☐ Male ☐ Female

Marital Status ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed Email _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

I prefer appt. confirmation via ☐ Text ☐ Email ☐ Phone Permission to leave detailed message? ☐ Yes ☐ No

How did you hear about us? _____ Preferred Dentist/Hygienist (if any) _____

Responsible Party (if different than Patient) _____ Relationship to Patient _____

Emergency Contact _____ Contact Phone Number _____

Please provide Dental Insurance Information below, or present Insurance Card at Check-In

PRIMARY DENTAL INSURANCE

Policy Holder _____

Policy Holder DOB _____

Relationship to Patient _____

Employer (or self) _____

Insurance Company _____

Group Number _____

Member ID or Policy Holder SSN _____

SECONDARY DENTAL INSURANCE

Policy Holder _____

Policy Holder DOB _____

Relationship to Patient _____

Employer (or self) _____

Insurance Company _____

Group Number _____

Member ID or Policy Holder SSN _____

I authorize Elk Dental Center to discuss all aspects of my dental treatment & account information to the individual(s) below:

Name(s) & Contact Information _____

HIPAA ACKNOWLEDGEMENT: I understand that as a part of my healthcare, Elk Dental Center originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment. Your personal health information will not be shared. I acknowledge that I have been provided with, and understand Elk Dental Center's Notice of Privacy Practices, which provides a complete description of the uses & disclosures of my health information. I understand that I have the right to review the Privacy Practices prior to signing.

SCHEDULING/MISSED APPOINTMENTS: When you schedule an appointment with Elk Dental Center, our team takes time to prepare in anticipation of serving your needs. If you need to reschedule an appointment, we kindly request you contact us by phone at least 48 hours prior to your scheduled appointment time. We understand that conflicts arise; however, if you fail to attend your schedule appointment without notice more than 3 times, we reserve the right to issue a warning letter, and possibly dismiss you from the practice if appointment failure continues. Thank you for your cooperation.

The undersigned authorizes full responsibility for the information on this form and for all charges for services performed at Elk Dental Center. I agree to pay all collection fees resulting from my failure or delinquency in payment. This also authorizes the release of any information relating to claims for benefits submitted on behalf of myself and/or dependents.

Signature of Patient/Responsible Party _____