middleton smiles
Family Dentistry

Patient Registration Form

Patient Name (First, MI, Last) _____ Preferred: _____

Date of Birth: _____ Sex: M F Married Single Divorced Widowed

Address_____ City_____ State _____ Zip_____

Preferred Phone#: _____ Is this a mobile #? Y N SSN#:_____

Employer: _____ Email Address: _____

Spouse, Parent(s) or Partner Information:

Name: _____ Phone #_____ DOB: _____

Employer: _____ SSN#: _____ Relationship to Patient: _____

Name: _____ Phone #_____ DOB: _____

Employer: _____ SSN#: _____ Relationship to Patient: _____

We routinely confirm appointments & communicate by text messaging to cell phones. (Standard text rates apply.) **Please mark the following box if you DO NOT WANT text messaging appointment reminders & communications:** ☐ (if pt is minor, parents would receive the reminders.)

Responsible Party (if different from previous listing)

First Name: _____ MI: _____ Last Name: _____ Sex: M F

Address_____ City_____ State _____Zip_____

Date of Birth: _____ Phone #:_____ SSN#:_____

Primary Dental Insurance: Is subscriber the same as patient? Yes No

Insurance Company: _____ Phone #:_____

Subscriber Name (Policy Holder): _____ Sex: M F

Subscriber ID/Policy Number: _____ Group # _____Date of Birth: _____

Patient Relationship to Subscriber: _____ Subscriber SSN#: _____

(SSN# is often used in the use of Insurance billing and benefits, it will ONLY be used for those purposed)

Secondary Dental Insurance:

Insurance Company: _____ Phone #:_____

Subscriber Name (Policy Holder): _____ Sex: M F

Subscriber ID/Policy Number: _____ Group # _____Date of Birth: _____

Patient Relationship to Subscriber: _____ Subscriber SSN#: _____

PAYMENT, INSURANCE & FINANCIAL POLICIES

*I verify that the identification & information I have provided is true and accurate and will update this office as changes occur.

*By signing below I acknowledge that I received and understand the Middleton Smiles Financial Policy and agree to abide by such policies.

NOTICE OF PRIVACY PRACTICES

*By signing this form, I give consent to Middleton Smiles to use and disclose my protected health information in order to carry out treatment, payment and healthcare operations. With my consent, I understand that Middleton Smiles may communicate with me via phone, text, mail, &/or email. I have the right to restrict how this communication is made and will notify our office accordingly. Please refer to Middleton Smiles Notice of Privacy Practices for a more complete description of such uses and disclosures.

*I have been offered, understand & agree to the Notice of Privacy Practices for Middleton Smiles in compliance with the Health Information Portability and Accountability Act of 1996 ("HIPAA").

Please list individual(s) whom we have permission to speak with regarding dental treatment & financial matters:

Name(s): _____

Signature:_____ Date:_____

Relationship to patient:_____