



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: _____

Responsible Party (Parent or Guardian, etc)

Name (First, MI, Last): _____ Sex: M F
 Address _____ City _____ State _____ Zip _____
 DOB: _____ Phone#: _____ Email Address: _____
 Employer: _____ SSN#: _____ Relationship to Patient: _____

Spouse, Parent(s) or Partner Information:

Name: _____ Phone # _____ DOB: _____
 Employer: _____ SSN#: _____ Relationship to Patient: _____
 Email Address: _____

We routinely confirm appointments & communicate by text messaging to cell phones. (Standard text rates apply.)

Please mark the box of your preferred method of contact: ☐ Wireless (cell) ☐ Text Message ☐ Email ☐ Home Phone Call

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 purposes)

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: _____