



Patient Registration

Patient Information

First Name: _____ Last Name: _____ M.I. _____

Address: _____

City: _____ State _____ Zip: _____ Home Phone: _____

Work Phone: _____ Ext. _____ Cellular: _____

Sex: _____ Male _____ Female Marital Status: _____ Married _____ Single

Soc. Sec. #: _____ Birth Date: _____ Age: _____

Employment Status: _____ Full Time _____ Part Time _____ Retired

Student Status: _____ Full Time _____ Part Time **Referred By:** _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ M.I. _____

Address: _____

City: _____ State/Zip: _____ Home Phone: _____

Work Phone: _____ Ext. _____ Cellular: _____

Soc. Sec. #: _____ Birth Date: _____ Age: _____

Primary Insurance Information

Name of Insured: _____

Relationship to Patient: _____ Self _____ Spouse _____ Child _____ Other

Insured Soc. Sec. #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: _____ Self _____ Spouse _____ Child _____ Other

Insured Soc. Sec. #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____



**ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

You May Refuse to Sign This Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)



Name: _____

Patient Survey Form

When was the last time you saw a dentist?

What is the reason for your visit today?

How were you referred to our practice?

What is most important to you about your teeth or smile?

What do you **dislike** about visiting the dentist?

Please list your 2 favorite radio stations:

- 1.
- 2.

Gender: (please circle)

MALE

FEMALE

Age: (please circle) 18-24

25-34

35-44

45-64

65+

Zip Code: _____