TODAY'S DATE_____

PATIENT REGISTRATION

PATIENT INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME		NICKNAME OR PREFERRED NAME
EMAIL				
ADDRESS				BIRTHDATE
CITY	STATE	ZIP		☐ MALE ☐ MARRIED ☐ FEMALE ☐ SINGLE
HOME PHONE ☐ PREFERRED	CELL PHONE ☐ PREFERRED	WORK PHONE ☐ PREFERRED		SOCIAL SECURITY NUMBER

IF PATIENT IS A MINOR, PROVIDE THE FOLLOWING	PARENT/LEGAL GUARDIAN FIRST NAME LAST NAME		RELATIONSHIP TO PATIENT ☐ PARENT ☐ GRANDPARENT ☐ OTHER ☐ LEGAL GUARDIAN	
	EMAIL ADDRESS			
	ADDRESS ☐ SAME AS ABOVE	CITY	STATE	ZIP
HOME PHONE ☐ PREFERRED	CELL PHONE ☐ PREFERRED	WORK PHONE ☐ PREFERRED	SOCIAL SECURITY NUMBER	
WITH WHOM DOES THE CHILD RESIDE? ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER (PLEASE SPECIFY)_____				

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT PERSON	PHONE NUMBER	RELATIONSHIP
NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU	PHONE NUMBER	RELATIONSHIP

THE BIGGEST COMPLIMENT OUR PATIENTS CAN GIVE US IS THE REFERRAL OF FAMILY & FRIENDS

WHOM MAY WE THANK FOR REFERRING YOU? PLEASE PROVIDE FULL NAME	ARE THEY A PATIENT HERE?	☐ YES ☐ NO – CHOOSE BELOW
HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ OUR WEBSITE ☐ BUILDING SIGN ☐ YOUR EMPLOYER ☐ MAILER/UNION HALL ☐ PUBLIC EVENT ☐ INSURANCE COMPANY ☐ ONLINE SEARCH ☐ SOCIAL MEDIA ☐ DENTAL CENTER EMPLOYEE_____		

IF YOU HAVE DENTAL INSURANCE, PLEASE PROVIDE THE FOLLOWING & YOUR INSURANCE CARD

PRIMARY CARRIER

INSURANCE COMPANY NAME	INSURANCE PHONE
EMPLOYER NAME	EMPLOYER PHONE
PRIMARY INSURED NAME	
BIRTH DATE	RELATIONSHIP TO PATIENT
INSURED INSURANCE I.D. NUMBER	GROUP NUMBER
INSURED SOCIAL SECURITY	
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME

SECONDARY CARRIER

INSURANCE COMPANY NAME	INSURANCE PHONE
EMPLOYER NAME	EMPLOYER PHONE
PRIMARY INSURED NAME	
BIRTH DATE	RELATIONSHIP TO PATIENT
INSURED INSURANCE I.D. NUMBER	GROUP NUMBER
INSURED SOCIAL SECURITY	
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME

PLEASE TURN OVER AND SIGN...

PATIENT REGISTRATION

ACKNOWLEDGEMENT & CONSENT

Acknowledgement of Insurance Payment Authorization: I hereby authorize and direct payment of the dental insurance benefits otherwise payable to me for services rendered, directly to Access Dental/Blue Hills Dental. In the event that the insurance company misdirects payment to me, I understand that I am responsible to immediately remit such payments to Access Dental/Blue Hills Dental.

Acknowledgement of Financial Responsibility: I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that either a 1-½% late charge (18% APR) or a $15 late charge per late payment may be added to my account. I further agree to inform Access Dental/Blue Hills Dental of any address or phone number change within 30 days of such a change. In the event I fail to do so I authorize Access Dental/Blue Hills Dental to use all due means, including the use of credit history records, to ascertain my new address for billing purposes.

Notice of Privacy Practices: I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Acknowledgment of Dental Materials Fact Sheet: I acknowledge that I have received and read the Dental Materials Fact Sheet prior to starting restorative dental work at Access Dental/Blue Hills Dental.

PATIENT SIGNATURE DATE

PARENT/RESPONSIBLE PARTY SIGNATURE DATE

RELATIONSHIP TO PATIENT