PATIENT REGISTRATION

Welcome! *Please complete the following confidential information*

PATIENT INFORMATION

NAME ____
(First) (Middle) (Last)

SOCIAL SECURITY # ____________________ DATE OF BIRTH ____________________

STREET ADDRESS ____________________ CITY ____________________ STATE______ ZIP__________

HOME PHONE ____________ CELL PHONE ____________ EMAIL ____________________

EMPLOYER: ____________________ WORK PHONE ____________________ EXT ________

RELATIONSHIP TO INSURANCE SUBSCRIBER (The person in your family who your insurance is through): ☐ Self ☐ Spouse ☐ Child ☐ Other

PRIMARY DENTAL INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: ____________________ ID # ____________________

NAME OF SUBSCRIBER ____________________ SOCIAL SECURITY # ____________
(First) (Middle) (Last)

STREET ADDRESS ____________________ CITY ____________________ STATE___ ZIP__________

HOME PHONE ____________________ CELL PHONE ____________________ DATE OF BIRTH ____________

EMPLOYER ____________________ EMPLOYER PHONE ____________________

SECONDARY DENTAL INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: ____________________ ID # ____________________

NAME OF SUBSCRIBER ____________________ SOCIAL SECURITY # ____________
(First) (Middle) (Last)

STREET ADDRESS ____________________ CITY ____________________ STATE___ ZIP__________

HOME PHONE ____________________ CELL PHONE ____________________ DATE OF BIRTH ____________

EMPLOYER ____________________ EMPLOYER PHONE ____________________

CONSENT:

1. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**: By signing below I acknowledge that I have received and reviewed a copy of this office's Notice of Privacy Practices according to federal and state requirements and I consent to the use of my records and information to carry out treatment, payment activities, and health care operations as set forth in this office's Privacy Notice.
2. I hereby authorize Dr. William J. Fitzgerald or designated staff to take X-rays, photographs and any other diagnostic aids deemed appropriate by Dr. William J. Fitzgerald to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Dr. William J. Fitzgerald to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. **I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Dr.William J. Fitzgerald. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless Dr. Fitzgerald has a contractual agreement with my plan prohibiting all or a portion of such charges.**

Patient/Guardian's Signature ______________________________ **Date** ____________