PATIENT REGISTRATION

Patient

Last Name_____First_____Middle_____
Parent/Guardian _____ Spouse_____
Address_____City_____State_____Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
Employer_____Occupation_____
Patient Social Security Number_____ Birthdate_____ M___F___
Married___ Single____ Divorced_____ Child____ Email:_____

Dental Insurance Primary Carrier

Insurance Company_____
Program/Policy#_____
Employer_____
Employee Name_____
Birthdate_____SSN_____
Relationship to Patient_____

Dental Insurance Secondary Carrier

Insurance Company_____
Program/Policy#_____
Employer_____
Employee Name_____
Birthdate_____SSN_____
Relationship to Patient_____

Medical History

Medical Doctor Name_____Location_____Phone_____
Are you under physicians care now?_____Reason_____
Are you Pregnant_____Due Date_____
Have you been hospitalized?_____
Have you ever had any of the following (Please Check)

___AIDS/HIV	___Fainting	___Lung Disease	___Ulcers	___High/Low Blood Pressure
___Arthritis	___Artificial Joint	___Prolonged Bleeding	___Stroke	___Heart Valve Replacement
___Asthma	___Glaucoma	___Pacemaker	___Cancer	___Osteoporosis Treatment
___Migraine	___Heart Trouble	___Tuberculosis	___Epilepsy	___Psychiatric Treatment
___Diabetes	___Hepatitis	___Emphysema		

Do you have any other condition or illness not listed here?_____
List current medications_____
List all drug allergies_____

Dental History

Last Dental Visit_____Last Full mouth x-rays taken_____
How often do you brush_____Floss_____Do you prefer nitrous oxide?_____
Have you had any unusual effects from previous dental treatment?_____ Describe_____
_____
What is the reason for your visit today?_____
_____
Are you happy with the appearance of your teeth?_____
Whom may we thank for referring you to our office?_____

I certify that the above information is accurate. I understand that I am responsible for all costs of dental treatment in this office for myself 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 a 1-1/2% late charge (18% APR) may be added to my account. I also understand that any insurance I have is a contract between the insurance company and myself and that I am responsible for the full account balance regardless of what my insurance company pays.

Signature_____Date_____

Insurance Authorization and Release

I authorize the dentist to release all information necessary to secure payment of benefits from my insurance company.

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature (insured person) _____Date _____

Notice of Privacy Practices Acknowledgement

I have received a copy of the Privacy Notice for **Dr. Lance G. Rencher, DDS**, **PLLC** . It details how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Privacy Notice.

_____ _____
Patient(s) Name Date

_____ _____
Signature Relationship to Patient

ﻑ I am choosing not to sign this form, received on _____.
ﻑ **Do Not** want my care discussed with:
ﻑ Family Members
ﻑ Spouse
ﻑ Caregivers
ﻑ Other _____