PATIENT REGISTRATION

NAME ____________________

HOW YOU LIKE TO BE ADDRESSED

____

HOME PHONE ___________________

CELL PHONE ____________________

E-MAIL __________________________

BIRTHDATE ____________________

SOCIAL SECURITY # ______________

REFERRED BY ____________________

EMPLOYER NAME ________________

INSURANCE PLAN _______________

INSURANCE ID#_________________

INSURANCE GROUP __________

POLICYHOLDER NAME _________

POLICYHOLDER BIRTHDATE ____

POLICYHOLDER SS# _____________

RELATIONSHIP TO PATIENT _____

IN CASE OF EMERGENCY NOTIFY:

____

CONSENT TO DISCLOSE

I authorize Grandview Dental, P.C. to use and disclose the dental, medical, and health information of ____
for purposes of treatment, payment, and health care operations associated with my care.

I have a right to review and secure a copy of a complete *Notice of Privacy Practices* and have the right to revoke this consent in writing.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN__________________________

DATE _____________________

SIGNATURE ON FILE *– Insured patients only*

PATIENT NAME ___________________________________

I authorize insurance payments due to me to be paid directly to Grandview Dental, P.C.

SIGNATURE ________________________ ***DATE*** _______________________

Signature is valid for two years from this date, unless revoked by me at an earlier date.