PATIENT REGISTRATION

NAME _____

HOW YOU LIKE TO BE ADDRESSED

_____

HOME PHONE _____

CELL PHONE _____

E-MAIL _____

BIRTHDATE _____

SOCIAL SECURITY # _____

REFERRED BY _____

INSURANCE PLAN _____

INSURANCE ID#_____

INUSRANCE GROUP #_____

POLICYHOLDER NAME _____

POLICYHOLDER BIRTHDATE _____

POLICYHOLDER SS# _____

RELATIONSHIP TO PATIENT _____

IN CASE OF EMERGENCY NOTIFY:

_____

CONSENT TO DISCLOSE

I authorize Grandview Dental, P.C. and Korwin D. King, DDS, 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.