PATIENT REGISTRATION

SECTION I — PATIENT INFORMATION

Name: _____ I prefer to be called: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone/E-mail:

❑ I consent to the dental practice using my cell phone or e-mail regarding appointments, treatment, insurance and my account.

I understand that I can withdraw my consent at any time. **Choose one or more:** ❑ Call ❑ Text ☐ Email

My Cell Phone Number is: *(include area code)* (_____) _____ _____ *(initial)*

My E-Mail Address is: _____ _____ *(initial)*

Other federal and state rules govern telemarketing and commercial e-mail messages.

A summary of these laws is available on the website of the Office of the Attorney General at *oag.ca.gov/privacy/privacy-laws*

Date of Birth: _____ Age: _____ Sex: M / F

Employer: _____ SSN#: _____ Drivers Lic. #: _____

Check appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse or Parent's Name: _____ Phone: (_____) _____

Person to contact in case of emergency: _____ Phone: (_____) _____

How did you hear about us?: ❑ Advertising: _____ ☐ Health Fair ☐ Internet ☐ Insurance Listings

☐ Physician ☐ Relative ☐ White Pages ☐ Yellow Pages ❑ Whom may we thank for referring you?: _____

SECTION II — RELEASE OF MEDICAL INFORMATION

☐ I hereby authorize Riverside Dental Group and Dental Associate Offices to release my health and billing information to:

◯ Spouse ◯ Mother ◯ Father ◯ Legal Guardian (First and Last Name) _____.

This release of information will remain in effect until terminated by me in writing.

☐ Information is **NOT** to be released to anyone.

SECTION III — RESPONSIBLE PARTY *(if different from Patient Information)*

Relationship to Patient: ◯ Self ◯ Spouse ◯ Mother ◯ Father ◯ Legal Guardian

Name: _____ DOB: _____ Driver License #: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Phone: (_____) _____

Employer: _____ Work Phone: (_____) _____ SSN#: _____

I hereby authorize the performance of services and procedures that are deemed necessary or advisable by the dentist and the dental auxiliary personnel, including the administration of anesthetics and/or sedatives. Furthermore, I agree to payment when services are rendered. I understand that my insurance policy is a contract between myself and my insurance company. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I recognize and accept responsibility for payment of services not covered by insurance benefits. I permit payment of insurance benefits directly to the dentist for services rendered. I also authorize a credit check, if needed, for balance carried over 30 days. I agree to pay an attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Responsible Party Signature: _____ Date: _____

–FOR OFFICE USE ONLY–

Account #_____ Subscriber # _____ Patient # _____

PATIENT REGISTRATION

PATIENT REGISTRATION cont.

SECTION IV **INSURANCE INFORMATION**

Insured Person: (person that carries the insurance)

Relationship to Patient: ❑ Spouse ❑ Mother ❑ Father ❑ Legal Guardian

Name: _____ DOB: _____

Employer: _____ Work Phone: (_____) _____ SSN#: _____

Insurance Company: _____ Group #: _____ ID#: _____

Ins Co Address: _____ Ins Co Phone: (_____) _____

--------- **DO YOU HAVE ANY ADDITIONAL INSURANCE?:** ❑ YES ❑ NO IF YES, COMPLETE THE FOLLOWING ---------

Relationship to Patient: ❑ Spouse ❑ Mother ❑ Father ❑ Legal Guardian

Name: _____ DOB: _____

Employer: _____ Work Phone: (_____) _____ SSN#: _____

Insurance Company: _____ Group #: _____ ID#: _____

Ins Co Address: _____ Ins Co Phone: (_____) _____

Dependents: Name: _____ SSN#: _____ DOB: _____

Name: _____ SSN#: _____ DOB: _____

The undersigned, hereby authorizes the release of any information relating to all claim or benefits submitted on behalf and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned has personally signed the particular claim until authorization is revoked in writing.

Date

_____

AUTHORIZED SIGNATURE OF COVERED PERSON/EMPLOYEE (YOU MAY RECEIVE A COPY OF THIS AUTHORIZATION ON REQUEST)

Date

_____

AUTHORIZED SIGNATURE OF COVERED PERSON/EMPLOYEE (YOU MAY RECEIVE A COPY OF THIS AUTHORIZATION ON REQUEST)