PATIENT REGISTRATION

Welcome! *Please complete the following confidential information*

PATIENT INFORMATION

NAME _____
(First) (Middle) (Last)

WHO MAY WE THANK FOR REFERRING YOU TO US? _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

EMPLOYER: _____ EMAIL _____

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: _____ GROUP/POLICY # _____

NAME OF SUBSCRIBER _____ SOCIAL SECURITY # _____
(First) (Middle) (Last)

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

DATE OF BIRTH _____ MARITAL STATUS: ☐ Married ☐ Single ☐ Other WORK PHONE _____ EXT _____

EMPLOYER _____ FULL-TIME OR PART-TIME EMPLOYEE (Circle One)

SECONDARY DENTAL INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____ GROUP/POLICY # _____

NAME OF SUBSCRIBER _____ SOCIAL SECURITY # _____
(First) (Middle) (Last)

DATE OF BIRTH _____ MARITAL STATUS: ☐ Married ☐ Single ☐ Other WORK PHONE _____ EXT _____

EMPLOYER _____ FULL-TIME OR PART-TIME EMPLOYEE (Circle One)

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. Amra Spahic-Musakadic or designated staff to take X-rays, photographs and any other diagnostic aids *deemed appropriate by Dr. Amra Spahic-Musakadic to make a thorough diagnosis of my dental needs. Upon such diagnosis,* authorize Dr. Amra Spahic-Musakadic to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary.
3. ***I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Dr. Amra Spahic-Musakadic. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the Dr. Amra Spahic-Musakadic has a contractual agreement with my plan prohibiting all or a portion of such charges.***
4. By signing below, **I certify that I read and write English and I have read, fully understand, and agree to the above items**.

Patient/Guardian's Signature _____ **Date** _____