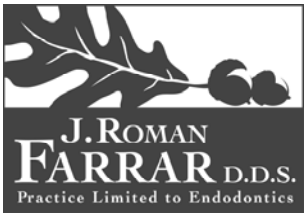

Date _____

Patient Registration

PATIENT INFORMATION (Please Print)

Title_____ First Name _____ MI _____ Last Name _____

Birthdate _____ Soc. Sec. # _____ Gender: MALE FEMALE

Mailing Address _____City / State / Zip _____

Physical Address (if different)_____

Phone #'s: Home _____ Work _____ Cell _____

Do you have insurance? Yes _____ NO _____ If yes, please give your card or information to our patient care coordinator.

Employer _____ Employer Phone # _____

Employer address _____ Occupation _____

Referring Doctor _____ General Dentist _____
(if not same as Referring Doctor)

Have you been seen in this practice before today? YES NO

PERSON RESPONSIBLE FOR ACCOUNT OR INSURANCE INFORMATION(if other than patient)

Title_____ First Name _____ MI _____ Last Name _____

Birthdate _____ Soc. Sec. # _____ Relationship to patient _____

Address _____

City / State / Zip _____

Phone #'s: Home _____ Work _____ Cell _____

Employer _____ Occupation _____

HIPPA - Notice of Privacy Practices Act for Dentists

Notice of Privacy Practices describes how health information about you may be used and disclosed and how you can get access to this information. A copy of the Notice of Privacy Practices pamphlet is located at the front desk for your review. We encourage you to review it carefully. The privacy of your health information is very important to us. We use and disclose health information about you for treatment, payment, and healthcare operations to a physician or other healthcare provider providing treatment for you. We must disclose your health information to you, as described in the Patients Rights section of the Notice of Privacy Practices pamphlet. We may only disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so. Please list below, the name and relationship of the person(s) other than your healthcare provider you are giving our office the consent to disclose your protected information. By signing this consent form, you are giving our office the consent to use and disclose your protected health information to carry out treatment, payment activities, and healthcare operations. You have the right to revoke this consent at any time by giving us written notice of your revocation.

_____ _____ _____ _____

Signature (Parent or Guardian, if patient is a minor) | Date | Signature of Authorized Representative of J. Roman Farrar, DDS | Date