NORTHSIDE DENTAL

Patient Registration

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Home Phone: (___) _____

City: _____ State/Zip: _____ Work Phone: (___) _____

Birth Date: _____ Age: _____ Cell Phone: (___) _____

Sex: ○Male ○Female Marital Status: _____ Social Security Number: _____

Email address: _____

EMERGENCY CONTACT: _____ Phone Number: _____

How would you prefer to receive appointment reminders? Please choose one.
○Phone Call – If so, which number: _____ ○Email ○Text Message

How did you hear about our office? _____

Dental Insurance Information:

Person responsible for account: _____
Last name First name Initial

Relationship to patient:_____ Date of Birth:_____ Soc. Sec. #:_____

Responsible party's employer: _____ Business phone:_____

Insurance company: _____ Phone number: _____

Group number: _____ Patient ID: _____

Responsible Party (If someone other than patient)

Name: _____ Date of Birth: _____

Address: _____ SS#: _____
_____

Home #: _____ Work #: _____ Cell #: _____

Regarding HIPAA:

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you information about our privacy practices. By signing below, you are acknowledging you have reviewed a copy of our HIPAA privacy handout.

Signature: _____
Date: _____