FAIR OAKS DENTAL, PA **PATIENT REGISTRATION** Chart ID: _____

Patient Name: _____ Birth Date: _____
Age: _____ Sex: F___ M___ Single____ Married____ Divorced____ Widowed____ Separated____ Other____
Soc. Sec. # _____ Drivers Lic. # _____ Address: _____
City, State, and Zip: _____ H# _____ Cell# _____
Work# _____ Ext: _____ Email: _____
Student Status: NA___ Full Time___ Part Time___ School Name: _____
Emergency Contact:_____ Relationship:_____ Phone#:_____

Responsible Party Name (Parent or Guardian): _____ Birth Date: _____
Age: _____ Sex: F___ M___ Single____ Married____ Divorced____ Widowed____ Separated____ Other____
Soc. Sec. # _____ Drivers Lic. # _____ Address: _____
City, State, and Zip: _____ H# _____ Cell# _____
Work# _____ Ext: _____ Email: _____
Student Status: NA___ Full Time___ Part Time___ School Name: _____

INSURANCE AND BILLING INFORMATION:
Name of Policy Holder:_____
Policy Holder Soc. Sec.:_____
Policy Holder Insurance ID:_____
Name of Employer:_____
Insurance Company:_____
Insurance Address:_____

_____ Do Not have Dental Insurance
Relationship to Patient:_____
Policy Holder Date of Birth:_____
Medicaid ID:_____
Employer Phone#:_____
Insurance Phone#:_____
City, State, Zip:_____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to FAIR OAKS DENTAL for professional or medical expenses benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHT AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtness to the above mentioned assignee, and I have agreed to pay, incurrent manner, any balance of said service charges over and above the insurance payment.
A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

HIPPA (Patient Consent Form)
Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patients Rights section describing your right under the law. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPA). The patient understands that.....
*Protected health information may be disclosed or used for treatment, payment or health operations.
*The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
*The practice has the right to change the Notice of Privacy Practices.
*The patient has the right to restrict the use of their information but the practice does not have to agree to those restrictions.
*The patient may revoke this consent in writing at any time and all future disclosures will then cease.
*The Practice may condition receipt of treatment upon the execution of this consent.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ DATE_____

Thank you for choosing FAIR OAKS DENTAL, PA. We look forward to working with you.