# PATIENT REGISTRATION

**WELCOME!!!** Please complete the following confidential information

PATIENT 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#_____

CELL PHONE#_____ E-MAIL ADDRESS_____

EMPLOYER_____WORK#_____

RELATIONSHIP TO INSURANCE SUBSCRIBER SELF SPOUSE CHILD OTHER

**PRIMARY DENTAL INSURANCE INFORMATION:**

NAME OF INSURANCE COMPANY_____

NAME OF SUBSCRIBER_____

EMPLOYER_____

INSURANCE TELEPHONE #_____

ID#_____ GROUP#_____

DATE OF BIRTH OF SUBSCRIBER ____/____/_____

CONSENT:

1. ACKNOWLEGEMENT 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 Deer Creek Dental staff to take xrays, photographs and other diagnostic aids deemed appropriate by Dr. Mark Vandenberg and/or Dr. Thanh Dao to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Drs Vandenberg and/or Dao 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 appropriated medication and therapy as deemed necessary.
3. I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Deer Creek Dental. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan.
4. By signing below I certify that I read and fully understand, and agree to, the above items.

Patient/Guardian Signature_____