



REGISTRATION

Patient's Name _____ Date of Birth _____ Age _____
Last First Middle Initial Male Female

How do you wish to be addressed _____

If Child: Parent's Name _____

Single Married Dependent

Residence: Street _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Work Phone _____

Email _____

Patient/Parent Social Security No. _____

Spouse/Parent Social Security No. _____

Patient/Parent Employed By _____

Spouse/Parent Name _____

Spouse Employed By _____

Who is responsible for this account _____

Dental Insurance Carrier(s) _____

Other family members in this practice _____

Whom may we thank for this referral _____

Someone to notify in case of emergency not living with you _____

HIPAA/Notice of Privacy Acknowledgment:

*Copy available upon request.

I understand that, under Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand and I have read this organization's *Notice of Privacy Practices* and may request in writing that you restrict how my privacy is used or disclosed for treatment, payment, or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions. I understand this organization has the right to change its *NPP* from time to time. I understand that if I have any questions/concerns, I may contact this office's privacy officer.

I authorize messages to be left on my email address and phone numbers provided. YES NO

Patient Name Relationship to Patient

Signature Date

I authorize Dr. Richardson and or his office staff to discuss my treatment and financial arrangements with the following people:

Spouse: _____ Children: _____
Name Name

Name of others: _____

Patient Name Signature

*This HIPAA authorization is good for 3 years.

Consent:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous payments agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. I attest to the accuracy of the information on this page.

PATIENT OR GUARDIAN SIGNATURE

Date _____