PATIENT REGISTRATION

Patient Last Name _____ First _____ Initial:_____

How do you wish to be addressed? _____ DOB_____ Soc. Sec. No _____

Single____ Married ____ Male____ Female ____ Full Time Student Y N School _____

Address _____ Apt. _____ City _____State_____ Zip _____

Telephone home (____) _____ work (_____) _____ Ext._____ cell_ (____)_____

E-Mail _____

Employer _____ Occupation _____

INSURANCE INFORMATION

Name of Subscriber

Last Name _____ First _____ Initial _____

DOB _____ Soc. Sec. No. _____

Address _____Apt. _____ City _____ State _____ Zip _____

Telephone home (____) _____ work (_____) _____ Ext. _____ cell (____) _____

Employer _____ Occupation _____

Dental Insurance Co. _____ Group # _____

SECONDARY INSURANCE

Name of Subscriber

Last Name _____ First _____ Initial _____

DOB _____ Soc. Sec. No. _____

Address _____Apt._____ City _____ State _____ Zip _____

Telephone home (____) _____work (_____) _____ Ext. _____ cell (_____) _____

Employer _____ Occupation _____

Dental Insurance Co. _____ Group # _____

CONSENT

Acknowledgement 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, and healthcare operations as set forth in this offices Privacy Notice.
I hearby authorize Dr. Kishel or designated staff to take x-rays, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Dr. Kishel to perform all recommended treatment mutually agreed upon by me. I consent to the use of appropriate medication and therapy as deemed necessary.

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Dr. Edward Kishel. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless Dr. Kishel has a contractual agreement with my plan prohibiting all or a portion of such charges.

By signing below I certify that I read and write English and I have read, fully understand, and agree to the above items.

Patient/ Guardian's Signature _____ DATE _____