PATIENT REGISTRATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you.

PATIENT INFORMATION

☐ UPDATE ☐ NEW PATIENT

Date:_____

Patient:_____,_____,_____,_____
LAST FIRST MI TITLE

☐ FEMALE ☐ MALE ☐ CHILD* ☐ STUDENT** ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

Patient Date of Birth:_____ Patient

SSN:_____

Address: _____ Phone Numbers:

Home: _____

_____

CITY ST ZIP Cell:

_____

Email: _____ Work: _____

Would you prefer to be contacted in the morning or afternoon? _____

Prefered Contact Method:_____Any Method Unauthorized:_____

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them)

***IF CHILD, PLEASE COMPLETE:**

_____

PARENT/GUARDIAN NAME

SSN:_____

****IF COLLEGE STUDENT, PLEASE COMPLETE:**

Student Status (full-time or part-time):_____

School/Location:_____

Other Parties Allowed Access to my Personal Health Information:

Name(s):_____Relationship(s):_____

In case of emergency, please provide information for the nearest relative or designated contact person:

_____

Tel:_____

NAME RELATIONSHIP

Any Form of Contact Not Authorized:_____

DENTAL HISTORY

When was your last dental visit? _____ Last dental provider:_____

INSURANCE ASSIGNMENT AND RELEASE

PATIENT REGISTRATION

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I certify that I, and/or my dependent(s), have insurance coverage with:_____ and assign directly to Dr. Moreno all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Moreno may use my health care information and may disclose such information in the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature (or signature of parent/guardian):_____ Date:_____