WATER TOWER DENTAL ltd

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# REGISTRATION

**Welcome to our office. Please complete the following confidential information.**

***Patient Information***

Patient's legal name _____ Preferred name _____
LAST FIRST MIDDLE

Social Security no. _____ Date of Birth _____ Sex: ☐ M ☐ F ☐ Prefer to self-describe _____

Address _____ Length of residence _____
STREET CITY STATE ZIP

Previous Address (if fewer than 3 years) _____
STREET CITY STATE ZIP

Marital Status ◯ Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced ◯ Life Partner

Cell _____ Home _____ Work _____ Preferred: ☐ Cell ☐ Home ☐ Work

Email _____ Occupation _____ Employer _____

Employer's Address _____
STREET CITY STATE ZIP

Person responsible for bill _____ Relationship to patient _____

If you were referred, please let us know by whom so that we may thank them. _____

***In case of emergency***

Name of emergency contact _____

Cell Phone _____ Home Phone _____ Work Phone _____

Address _____
STREET CITY STATE ZIP

****Additional account information***

Spouse/partner's name _____ Relationship to patient _____ Phone no. _____

Please list any other family members who are patients with our office _____

*** For purposes of notification, we need to be apprised of your marital status in case something happens to you. Especially in cases where you lose consciousness, we have to obtain permission from your closest relative, which, in most jurisdictions, is presumed to be your spouse. If you are single, most jurisdictions again, your closest relative, parent, sibling, etc. is the one contacted. If you are separated, but not yet divorced your spouse is still the one who would have the right to direct care if you are unconscious. Please be clear on your paperwork about who has the right to decide how you are cared for. It lets us know who is your support system. It also helps to know this information for billing purposes and insurance. If you add someone to your HIPAA form to allow our dental team to talk to them about your medical condition and billing status this information may be helpful.*

## DENTAL INSURANCE INFORMATION

**If you are the person responsible for the bill, please put "self" and skip to the Insurance Company line.**

Insured's name _____
LAST FIRST MIDDLE

Date of Birth _____ Relationship to patient _____ Is this person a patient here? ☐ Yes ☐ No

Insured's Address (if different from above) _____
STREET CITY STATE ZIP

Phone no. _____ Insured's Social Security no. _____

Occupation _____ Employer _____

Employer's Address _____
STREET CITY STATE ZIP

***Primary Insurance***

Insurance Co. _____ Phone no. _____

Group no. _____ Policy/ID no. _____

Address _____
STREET CITY STATE ZIP

**You will receive a confirmation email 24-48 hours in advance of your appointment.**
☐ **Please check here if you prefer to be contacted by phone.**
**In support of environment-friendly initiatives, billing statements and other information are emailed to you.**
☐ **Please check here if you wish to be mailed a paper statement also.**

## CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs. ____ (Please initial)
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. ____ (Please initial)
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. ____ (Please initial)
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available. ____ (Please initial)
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. ____ (Please initial)

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Water Tower Dental Ltd. I understand that I am responsible for any co-pay and balance. I also authorize Water Tower Dental Ltd. or insurance company to release any information required to process my claim.

Signature _____ Print Name _____ Date _____

Relationship to patient _____ Witness _____