REGISTRATION

Date: ____/____/_____ **PATIENT INFORMATION**

Patient Name: _____ **Preferred Name:** _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number: (____) ____ - _____ Cell Phone Number: (____) ____ - _____

Date of Birth: _____ Male: _____ Female: _____ Social Security Number: _____-_____-_____

Driver's License # _____ Email (optional): _____

Circle: Married / Single / Divorced / Widowed Spouse's Name: _____

Employer Name: _____

Work Phone Number: (____) ____ - _____ Extension: _____ (Can we leave a message?) ☐/☐

Are there any other family members currently a patient in our office? ☐/☐

If so… Name: _____ Relationship: _____

Whom may we thank for referring you? _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to patient: _____

Home Phone Number: (____) ____ - _____ Work Phone Number: (____) ____ - _____

CONSENT FOR TREATMENT

I hereby authorize doctor or designated staff to take radiographs, study models, photographs and any other diagnostic aids deemed appropriate and necessary for treatment and thorough diagnosis of my or my minor child's dental needs.

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.

I agree to the use of anesthetics, sedatives, and other medications necessary for my dental treatment. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications of treatment, anesthetics, and medications.

ASSIGNMENT OF BENEFITS

I hereby authorize that payment of the amount due me in my pending insurance claim be made directly to Hilltop Dental. Payment is authorized upon your receipt of an itemized statement of services. I accept responsibility for any balance. We are happy to help you utilize your insurance to the best of our ability, and will try to assist you with any questions. However, we do remind you that your insurance benefits are through your employers, not through us. If you have specific questions concerning your benefits and covered procedures, we encourage you to check directly with your insurance company or your employer's benefit's manager.

Patient / Guardian Signature: _____ Date: ____/____/_____

Relationship to Patient: _____ (ex: Parent / POA)

HILLTOP DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided the opportunity to review this office's Notice of Privacy Practices. At my request, I have been given a copy of this office's Notice of Privacy Practices.

You may refuse to sign this acknowledgement

Signature	Date
Please Print Name	Home Phone Number
Home Address	Work Phone Number
Name of Insurance Company	Policy Number
Address of Insurance Company	Telephone Number

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☑ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____