PATIENT REGISTRATION

Please take a moment to fill out this Information in order to ensure that we have the most current information for you and be able to provide you with the best service• possible. TODAY'S DATE _____

PATIENT NAME (Last) _____(First)_____ MI_____ Preferred Name _____

BIRTH DATE _____ AGE_____ GENDER (M / F) MARITAL STATUS_____

RESIDENCE Street_____ City _____State _____ Zip_____

MAILING ADDRESS Street_____ City _____State _____ Zip_____

PHONE #'S Home_____ Cell _____ Work _____

EMPLOYER _____ E-MAIL_____

DRIVER'S LICENSE # _____Who may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

PATIENT NAME (Last) _____(First)_____ MI_____ Preferred Name _____

BIRTH DATE _____ AGE_____ GENDER (M / F) MARITAL STATUS_____

RESIDENCE Street_____ City _____State _____ Zip_____

MAILING ADDRESS Street_____ City _____State _____ Zip_____

PHONE #'S Home_____Work _____ Ext_____ Pager/Cell_____

E-MAIL_____ EMPLOYER_____DRIVER'S LICENSE # _____

RESPONSIBLE PARTY'S SPOUSE	EMERGENCY INFORMATION (Relative not living with you)
NAME_____ LAST First MI	NAME_____ Relationship _____
BIRTH DATE _____	ADDRESS _____ CITY/STATE _____
EMPLOYER _____	PHONE #'S Home _____ Work_____
PHONE #'S Home _____ Work_____	Pager/Cell _____ Work Ext_____
Pager/Cell_____ Work Ext _____	
DENTAL INSURANCE (PRIMARY)	If you have double dental insurance coverage, complete this for the second coverage.
Insured's Name _____	Insured's Name _____
Insurance Co._____	Insurance Co.,. _____
Insurance Co. Phone Number _____	Address _____
Address _____	Insured's Employer _____
Insured's Employer_____	Insured's Id# _____Birth date_____
Insured's SS#_____Birth date_____	
Insured's ID #_____Insured's Group # _____	

HIPPA PRIVACY POLICIES

We are required by law to maintain the privacy of, and provide individuals with, notice of our legal duties and privacy practices with respect to protected health information, By signing below you acknowledge that you have been offered a copy of the federal HIPPA privacy practices. _____(Initials)

Also, for accounting/bookkeeping purposes, I agree to allow Dr. Daniel P. Rooke, DMD list information regarding all family members' dental services or account information on one statement. _____(Initials)

PATIENTS WITH INSURANCE FINANCIAL RESPONSIBILITY AGREEMENT

I,_____understand that, although I have assigned insurance• benefits to this office, my insurance company will pay claims based on a fee schedule negotiated between my employer and the insurance company, assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid The dental fees incurred. I further understand that it is very possible that there may be a balance remaining after my claims have been paid and that it is my responsibility to pay that balance upon the next billing date. _____(Initials)

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. With my permission, I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated.

Signed_____ **Date** _____