FAMILY DENTISTRY OF MUKILTEO

Adult Patient Registration

Today's Date

First M. Last

Address City/ZIP

Cell# Home#

Work# DOB SS#

Marital Status Email

Employer Occupation

Who may we thank for referring you?

Primary Dental Insurance

Company ID#

Subscriber Name Sub Relationship to Patient

Subscriber Birth date Employer

Sub SSN# Group#

Sub Address

Secondary Dental Insurance

Company ID#

Subscriber Name Sub Relationship to Patient

Subscriber Birth date Employer

Sub SSN# Group#

Sub Address

Emergency Information

Name of person to contact in case of patient emergency

Relationship to patient Phone#

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the statement of Privacy Practices from Family Dentistry of Mukilteo. The statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The statement of Privacy Practices also describes my rights and the responsibilities and duties of the office with respect to my protected health information. Family Dentistry of Mukilteo reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If they change, I will be offered a copy of the revision and may request that it be mailed to me. A current copy is also always posted in the waiting room.

I hereby specifically authorize disclosure of my protected health care information to the following persons:

I have filled in my information to the best of my ability and understand that it will be used to bill my dental insurance and to acknowledge receipt of the Notice of Privacy Practices.

Printed Name **Signature**