Concept Dental
Lynnwood, WA 98036
Phone: (425) 697-3907

PATIENT REGISTRATION

First Name: _____ **Last Name:** _____ **Middle Initial:** _____
Patient is: ☐ Policy Holder **Preferred Name:** _____
☐ Responsible Party **Preferred Pharmacy:** _____ **Phone:** _____

Address: _____ **Address 2:** _____
City, State, Zip: _____ **Pager:** _____
Home Phone: _____ **Work Phone:** _____ **Ext:** ____ **Cell:** _____

Sex: ○ Male ○ Female **Marital Status:** ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ **Age:** _____ **Soc Sec:** _____ **Drivers Lic:** _____
Email: _____ ☐ I would like to receive correspondences via email
Employment Status: ○ Full Time ○ Part Time ○ Retired
Student Status: ○ Full Time ○ Part Time
EMERG CONTACT: _____
Relationship to Patient: _____
Phone number: _____

How did you hear about our office?
○ Website ○ TV ○ Yellow Pages
○ Google ○ Friend _____
○ Doctor _____
○ Other _____

Responsible Party (if someone other than patient)

First Name: _____ **Last Name:** _____ **Middle Initial:** _____
Address: _____ **Address 2:** _____
City, State, Zip: _____ **Pager:** _____
Home Phone: _____ **Work Phone:** _____ **Ext:** ____ **Cell:** _____
Birth Date: _____ **Soc Sec:** _____ **Drivers Lic:** _____

○ Responsible Party is also Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Policy Holder: _____ **Relationship to patient:** ○ Self ○ Spouse ○ Child ○ Other
Policy Holders Soc Sec: _____ **Policy Holders Birth Date:** _____
Policy Holders Employer: _____
Employer Address: _____ **City, State, Zip:** _____

Insurance Company: _____ **Phone Number:** _____
Address: _____ **City, State, Zip:** _____

Secondary Insurance Information

Name of Policy Holder: _____ **Relationship to patient:** ○ Self ○ Spouse ○ Child ○ Other
Policy Holders Soc Sec: _____ **Policy Holders Birth Date:** _____
Policy Holders Employer: _____
Employer Address: _____ **City, State, Zip:** _____

Insurance Company: _____ **Phone Number:** _____
Address: _____ **City, State, Zip:** _____

Please fill out reverse side ⟹

Concept Dental
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Lynnwood, WA 98036
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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to my privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Policy.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

- I give my permission to the above provider to leave messages at my contact phone numbers regarding appointments and treatment, with the following exceptions_____

Patient Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

FOR OFFICE USE ONLY:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign ☐ Communication barriers ☐ Emergency situation

☐ Other_____