PROGRESSIVE FAMILY DENTISTRY

HIPAA Registration Form

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Status: [ ]Child [ ]Single [ ]Married [ ]Widowed [ ] Separated [ ] Divorced

Mailing Address: _____ Apt#_____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Sex: [ ] Male [ ] Female Social Security # _____-_____-_____

Race: [ ]American Indian/Native Alaskan [ ]Asian [ ]Black/African American [ ]Hispanic/Latino Native [ ]White [ ]Other

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Email Address:_____ Primary Care Physician: _____

Emergency Contact: _____ Phone Number: (___)_____-_____ Relationship to Patient: _____

Occupation/Employer: _____

Student Status: [ ]Full Time [ ]Part Time Name of College/University: _____

INSURANCE INFORMATION

Primary Insurance: _____ Subscriber Name: _____ Subscriber's Employer: _____

Group/Plan#:_____ ID#:_____ Subscriber's Date of Birth: ____/____/____ Subscriber's Social Security Number:_____-____-_____

Secondary Insurance:_____ Subscriber Name: _____ Subscriber's Employer: _____

Group/Plan#: _____ ID#: _____ Subscriber's Date of Birth: _____/_____/_____ Subscriber's Social Security Number: _____/____/_____

How were you referred to us? [ ] Family/Friend [ ] Internet/Website [ ] Facebook [ ] Walk-in [ ] Apple Sign [ ] Insurance

If personally referred, whom may we thank for the referral?

_____

Guarantor Information (If patient is a Minor or Dependent)

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ Apt# _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/_____/_____ Sex: [ ] Male [ ] Female Social Security Number: _____-_____-_____

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

Relationship to Patient: _____ Email Address: _____

Communication Preference

In order for our office to better serve you, please indicate your communication preferences. By checking the boxes below, I consent that Progressive Family Dentistry may contact me to provide health care information, such as appointment reminders and information about treatment, payment, my account or insurance, and other communications.

What is your primary phone contact? [ ] Cell [ ]Home [ ]Work May we communicate with you by phone? [ ] Yes [ ] No

May we communicate with you by email? [ ] Yes [ ] No May we send you text messages? [ ] Yes [ ] No

Signature:_____ Date: _____