Patient Registration
for
p., piero d.d.s.

Patient Name___________________________________ Date of Birth_______________

Address______________________City_________________State_____Zip_________________

Home#________________________ Cell#___________________________

E-mail_________________________________(We do not sell or give away email addresses.)

Patient's social security #____

Patient employed at _____________________________Phone#________________________

Male/Female ___Marital Status____________________ Spouse's Name__________________

Name of person who holds insurance _______________________

SS#_____________________ Date of Birth_______________

Name of Insurance Company____

Company where person who holds insurance is employed_________________________________

Secondary Insurance Information

Person who holds secondary insurance_________________________________

Phone#_____________________ Date of Birth __________________________________

Social Security # _______________________________________

Insurance Company name ____

Place of employment____

Patient Registration

Page 2

We are committed to providing you with the best dental care possible. If you have dental Insurance, we are ready and willing to help you receive your maximum allowable benefits. We must emphasize that as a dental care provider, our relationship is with you, not your insurance company.

All charges are your responsibility from date services are rendered, an estimated co-payment and/or deductible will be collected at that time. There is no payment plan available.

Filing insurance claims is a courtesy our office provides.
If you do not wish us to file for you, then payment in full at time of visit is required.

To be a patient here you must keep your agreements and appointments. As an office we are proud to be able to give you the personal care we do. Your appointment time is scheduled just for you. No shows and less than 24 hour cancellations jeopardize our service and are not acceptable.
A 24 hour notice is required for all cancellations or a $25.00 fee will be charged.

Signature____Date_____________

Emergency
contact___________________________Phone#_________________________

Referred to our office by___________________________________

If patient is a minor, name the person responsible for account___________________________

Medical Information

Patient's name____

Primary Health Care Physician____

Do you have any general health problems? Yes ________ No _______

If yes, please explain____

Please circle if you have had any of the following:

Rheumatic Fever	Kidney Troubles	Hepatitis
Heart attack / Stroke	Arthritis	Liver Diseases
Low Blood Pressure	Rheumatic Heart Disease	Tuberculosis
Abnormal Bleeding	High Blood Pressure	HIV (positive result)
Asthma	Blood Disorders	Diabetes
Seizures / Fainting Spells	Prolonged Healing / Bruise Easy	Thyroid

Other ____

Cancer (what type?)____

Females: Are you pregnant?_______________________

Have you had a hip or knee replacement
surgery?____

Are you allergic to any
medications?____

Please list any medications you are currently taking__________________________________

____

The above information is accurate and true, by signing my signature below I agree to be examined and treated by Dr. P. Piero.

Signature____ Date____________

For the office of
p., piero d.d.s.

HIPAA Patient Acknowledgement of Notice of Privacy Practices

Full Name ____. By signing this Patient Acknowledgement of Notice of Privacy Practices, I hereby acknowledge that the NOTICE OF PRIVACY PRACTICES for the office of **p., piero d.d.s.** has been provided to me to read and review.

I may request a written copy at any time.

Signed by: ________________________ ______________ ____________________

Signature of Patient or Legal Guardian | Date | Relationship to Patient

________________________ __________________________

Print Patient's Name | Print Legal Guardian Name, if applicable

HIPAA Patient Disclosure Authorization Form

Full Name ____. By signing this Disclosure Authorization, I hereby authorize **p., piero d.d.s. and authorized staff** to use or disclose my protected health information related to **dental health** to **other dental health care professionals &/or insurance companies** to carry out treatment, payment and health care operations.

The practice **will not** receive payment or other remuneration from a third party in exchange for using or disclosing the protected health information.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **p., piero d.d.s.** may decline to provide treatment to me.

Signed by: ________________________ ______________ ____________________

Signature of Patient or Legal Guardian | Date | Relationship to Patient

________________________ __________________________

Print Patient's Name | Print Legal Guardian Name, if applicable