



## REGISTRATION FORM

(Please Print)

### PATIENT INFORMATION

Patient's last name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Sex:

Preferred Name: \_\_\_\_\_  Female  Male Birthdate: \_\_\_\_\_ Social Sec: \_\_\_\_\_

Street address: \_\_\_\_\_ P.O. Box \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Options for Appointment Confirmation (*mark all that apply*):  Phone  Text Message  Email

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Email Address: (*optional*): \_\_\_\_\_

Parents' or Guardian's Name (*if under the age of 18*): \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

### DENTAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Policy Holder's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Relationship to Policy Holder:

Social Sec: \_\_\_\_\_ Employer: \_\_\_\_\_  Self  Spouse  Child  Other

### IN CASE OF EMERGENCY

Name of friend or relative: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### ACKNOWLEDGEMENT OF NOTICE OF PRIVATE PRACTICES

I hereby acknowledge I have received a copy of Roberts & Hall Notice of Privacy Practice.

\_\_\_\_\_  
Print Name Signature Date

\*You may refuse to sign this acknowledgement

#### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

Individual refused to sign  Communication barrier prohibited obtaining the acknowledgment  Other \_\_\_\_\_