Russell Street Dental Associates LLC **Registration** **PT. ID# __________**

Patient Information:

First Name: ______________________ MI: ________ Last Name: ______________________ Preferred: __________

Address: ______________________ City: ______________________ State: __________ Zip: __________

Date of Birth: ______________ SS #: ______________________ Sex: ◯ Female ◯ Male

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed ◯ Domestic Partner

E-Mail Address: ______________________ ◯ I would like to receive correspondences via e-mail.

Check preferred contact number:

◯ Home: ______________ ◯ Work: ______________ Ext: ________ ◯ Cell: ______________

Student Status: ◯ Full Time ◯ Part Time School Name: ______________________ City & State: ______________

Emergency Contact Person: ______________________ Relationship to Patient: __________ Phone #: ______________

◯ **Not Covered by Dental Insurance – Self Pay**

Insurance Information: (If patient is the insurance policy holder, duplicate information fields may be skipped)

Primary Dental Insurance Company: ______________________ Subscriber's Employer: ______________________

Subscriber of Insurance: ______________________ DOB of Subscriber: __________ Relationship to Patient: __________

Subscriber SS #: ______________________ Alternate ID #: ______________________ Group #: ______________

Secondary Dental Insurance Company: ______________________ Subscriber's Employer: ______________________

Subscriber of Insurance: ______________________ DOB of Subscriber: __________ Relationship to Patient: __________

Subscriber SS #: ______________________ Alternate ID #: ______________________ Group #: ______________

Referrals: We would love to know how you were referred to us: ◯ Dental Website ◯ Insurance Company/Website ◯ Phonebook ◯ Mailer/Postcard ◯ Driving By/Window ◯ Patient or Provider: ______________________

Acknowledgements:

Insurance Assignment & Release: I certify that I and/or my dependents have insurance coverage as specified above and assign Russell Street Dental Associates LLC all insurance benefits, if any, otherwise payable to me for services rendered. Russell Street Dental Associates LLC may use and disclose my health information to the above named insurances and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions. **I understand that I am financially responsible for all charges whether or not paid by insurance.**

Receipt of Notice of Privacy Practices: I certify that I have been provided a copy of this office's Notice of Privacy Practices. (Separate Printout)

I, __________ **Print Patient Name** __________, have provided accurate information to the best of my ability.

____ ______________________

Signature of Patient/Guardian **Date**