PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

1

IF THIS APPOINTMENT IS FOR YOU, START HERE

DATE			
LAST NAME	FIRST		M.I.
PREFERS TO BE CALLED BY	SO. SECURITY #		
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE	FAX NUMBER		
CELL PHONE	EMAIL		
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED

IF THIS APPOINTMENT IS FOR YOUR CHILD, START HERE

DATE			
LAST NAME	FIRST		M.I.
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE	SO. SECURITY #		
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL	GRADE		

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL OUT THE TOP BOX ALSO.

DENTAL INSURANCE

2

PRIMARY CARRIER
INS. COMPANY
GROUP NO.
EMPLOYER
INSURED'S NAME
D.O.B.
RELATIONSHIP TO PATIENT
INSURED'S ID#
INSURED'S SS#
SECONDARY CARRIER
INS. COMPANY
GROUP NO.
EMPLOYER
INSURED'S NAME
D.O.B.
RELATIONSHIP TO PATIENT
INSURED'S ID#
INSURED'S SS#

ACCOUNT INFORMATION

4

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME	SS#	
RELATIONSHIP TO PATIENT	PHONE	
ADDRESS		
CITY	STATE	ZIP

YOU	
NAME	OCCUPATION
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE	FAX

YOUR SPOUSE	
NAME	OCCUPATION
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE	FAX

GETTING TO KNOW YOU

3

IS ANOTHER FAMILY MEMBER/RELATIVE A PATIENT AT OUR OFFICE?		
NAME	RELATIONSHIP	
YOU WERE REFERRED TO US BY		
CITY	STATE	ZIP

PERSON TO CONTACT FOR EMERGENCY		
NAME	PHONE	
ADDRESS		
CITY	STATE	ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU		
NAME	PHONE	
ADDRESS		
CITY	STATE	ZIP

FINANCIAL AGREEMENT

In the event of my default of payment to Dr. Susan H. Mauk as I have agreed, I agree to allow Dr. Susan H. Mauk to file any and all legal proceedings in Steuben County, Indiana. I further understand that I will be responsible for any out-of-pocket expenses, including reasonable costs for collections and attorney's fees. I further understand that in the event of my default regarding payment, that information regarding my account will be released to our collection attorney.

Patient's Signature _____ **Date** _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by Dr. Susan H. Mauk to make a thorough diagnosis of the below-signed patient's dental needs.

2. Upon such diagnosis, I authorize Dr. Susan H. Mauk to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to Dr. Susan H. Mauk's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are no received by agreed-upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ **Date** _____ **Witness** _____

Parent/Responsible Party's Signature _____ **Relationship to Patient** _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Dr. Susan H. Mauk, D.D.S. **1003 W. Toledo Street, Box 667** **Fremont, Indiana 46737** **(260) 495-2255**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA). 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 or 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 change the NOTICE OF PRIVACY PRACTICES and that I may contact this office at the address above to obtain a copy of the NOTICE OF PRIVACY PRACTICES.

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 agree, then you are bound to abide by such restrictions.

Patient's Name _____ **Date** _____

Patient's Signature _____ **Relationship to Patient** _____

Dependent family members also covered by the acknowledgement _____

FOR OFFICE USE ONLY

☐ PATIENT REFUSED TO SIGN ☐ COMMUNICATION BARRIERS ☐ EMERGENCY SITUATION