SHAVANO PARK FAMILY DENTISTRY, P.A.
PATIENT REGISTRATION

Chart ID: _____
Patient Name: _____
Birth Date: _____ Age: _____ Soc. Sec. _____ Drivers Lic: _____
Address: _____ City, State, And Zip: _____
H# _____ Cell# _____ Wk# _____ Ext: _____
E-mail: _____ I would like to receive correspondences via e-mail.
Student Status: NA Full Time Part Time School Name: _____

Responsible Party Name: _____
Birth Date: _____ Age: _____ Soc. Sec. _____ Drivers Lic: _____
Address: _____ City, State, And Zip: _____
H# _____ Cell# _____ Wk# _____ Ext: _____
E-mail: _____

PRIMARY INSURANCE INFORMATION
Name of Policy Holder: _____ Relationship to Patient: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Insurance ID#: _____ Medicaid ID#: _____
Employer: _____ Group#: _____
Ins. Company: _____ Phone #: _____
Address: _____ City, State, and Zip: _____

I hereby instruct and direct _____Insurance Company to pay by check made out and mailed to Shavano Park Family Dentistry, P.A. for professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in current manner, any balance of said service charges over and above the insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

HIPPA (Patient Consent Form)

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). The patient understands that…..

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this consent.

_____ _____
Signature of Policy Holder Date Printed Name

Patient Name: _____

SECONDARY INSURANCE INFORMATION

Name of Policy Holder: _____
Insured Soc. Sec: _____
Insurance ID#: _____
Employer: _____
Ins. Company: _____
Address: _____

Relationship to Patient: Self Spouse Child Other
Insured Birth Date: _____
Medicaid ID#: _____
Group#: _____
Phone #: _____
City, State, and Zip: _____