Patient Registration

Bagdad DENTAL

Date: _____ Who may we thank for referring you? _____

Patient Information

Name: _____ Birth Date: _____ SS #: _____

Street Address: _____ P.O. Box #: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

(Cell) _____ Email: _____

Gender: _____ Marital Status: _____

Spouse Name: _____ Employer: _____

Person Responsible for Account

☑ Check here if same as above and continue with next section

Name: _____

Relationship: _____ Birth Date: _____ S.S. #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

Dental Insurance Information

Primary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ S.S. #: _____

Birth Date: _____ Employer: _____

Policy #: _____ People Soft #: _____

Secondary Insurance Co (if applicable): _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ S.S. #: _____

Employer: _____ Policy #: _____

By signing, I understand that payment is my obligation regardless of insurance or any other third-party involvement.

Signature: _____ Date: _____

HIPPA Privacy Statement

I acknowledge that I have received the Notice of Privacy Practices. I authorize this office to use and disclose protected health information for the purposes of healthcare operations, treatment, and payment activities. For questions concerning our privacy policies, please contact our office at (928) 778-4110.

Signature: _____ Date: _____