KREUZER FAMILY DENTISTRY

PATIENT REGISTRATION

Patient Information

Date: _____

Patient's First Name: _____ Last Name: _____

Preferred Name: _____ DOB: _____ Sex: ○ Male ○ Female

Social Security Number (Required): _____ Marital Status: _____

Mailing Address: _____

Home Phone: _____Cell Phone: _____ Work Phone:_____

Preferred Method of Contact: _____ Would you like to received text confirmations/ reminders?: ○ Yes ○ No

Dental Insurance

Policy Holder's Full Name: _____ DOB: _____

Relationship to Patient: _____ Insurance Company: _____

Social Security Number: _____ Member ID: _____

Group Number: _____ Employer: _____

Notice of Privacy Practices

Acknowledgement of Receipt of Notice of Privacy Practices Posted. Copies available upon request.
I have read over this office's Notice of Privacy Practices records and materials.

X _____ Date: _____

----------For Office Use Only----------

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

Authorization

I authorize Kreuzer Family Dentistry to release any information, including diagnosis and record of treatment rendered to the patient to third party payors and/or health practitioners. I authorize and request my insurance company to assign benefits to Kreuzer Family Dentistry. I agree to be financially responsible for payment of all services rendered on my behalf of my dependents.

Patient/ Parent or Guardian Name: _____

X _____ Date: _____