Patient Registration Form

Date: ____/____/_____

Patient Information

Patient last name:_____ Patient first name:_____ Middle initial:_____
Preferred name:_____ Date of birth:_____ Sex at birth: ☐ Male ☐ Female
Social Security #:_____ School:_____ Cell Phone:_____
Email address(s):_____ _____ Home Phone:_____
Home address:_____ City, State, Zip:_____

Parent/Guardian (if under 18)

Custodial guardians name(s):_____
Patient lives with (check all that apply): ☐ Mother ☐ Stepmother ☐ Stepfather ☐ Grandparents ☐ Other: _____
Primary guardian full name:_____ Date of birth:_____
Occupation:_____ Email address:_____ Cell Phone:_____
Address (if different):_____ City, State, Zip:_____ Work Phone:_____
Secondary guardian full name:_____ Date of birth:_____
Occupation:_____ Email address:_____ Cell Phone:_____
Address (if different):_____ City, State, Zip:_____ Work Phone:_____

Financial

Who is financially responsible for this account?_____ Cell Phone:_____
Address:_____ City, State, Zip:_____ Home Phone:_____
Social Security #:_____ Email address:_____ Employer: _____

Dental/Orthodontic Insurance(s)

Primary policy holder's full name:_____ Date of birth:_____
Social Security #:_____ Relation to patient:_____ Sex at birth: ☐ Male ☐ Female
Address:_____ City, State, Zip:_____ Cell Phone:_____
Employer:_____ Insurance Company:_____ Policy #:_____
Group #:_____ Insurance Phone #:_____

Secondary policy holder's full name:_____ Date of birth:_____
Social Security #:_____ Relation to patient:_____ Sex at birth: ☐ Male ☐ Female
Address:_____ City, State, Zip:_____ Cell Phone:_____
Employer:_____ Insurance Company:_____ Policy #:_____
Group #:_____ Insurance Phone #:_____

Vision/Medical Insurance(s)

Primary policy holder's full name:_____ Date of birth:_____
Social Security #:_____ Relation to patient:_____ Sex at birth: ☐ Male ☐ Female
Address:_____ City, State, Zip:_____ Cell Phone:_____
Employer:_____ Insurance Company:_____ Policy #:_____
Group #:_____ Insurance Phone #:_____

Secondary policy holder's full name:_____ Date of birth:_____
Social Security #:_____ Relation to patient:_____ Sex at birth: ☐ Male ☐ Female
Address:_____ City, State, Zip:_____ Cell Phone:_____
Employer:_____ Insurance Company:_____ Policy #:_____
Group #:_____ Insurance Phone #:_____

Physician(s)

Patient Physician:_____ City, State:_____
Last seen:_____ Reason for visit:_____ Last physical:_____

Other Physicians/Healthcare providers:_____ City, State:_____
Reason for care:_____

Other Physicians/Healthcare providers:_____ City, State:_____
Reason for care:_____

Notice of Privacy

Acknowledgment of Receipt of Notice of Privacy Practices Posted. Copies available upon request.

I have been offered and read this office's Notice of Privacy Practices.

_____ ____/____/_____

Patient Signature (or guardian if under 18) Date

**********For Office Use Only**********

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

☐ Individual refused to sign ☐ Communication barriers prohibited obtaining acknowledgment.

☐ An emergency situation prevented us from obtaining acknowledgment. ☐ Other_____

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Information Sharing

I understand that this practice is part of a network of dental, vision, and orthodontic practices that includes separate entities. By signing below, I authorize the sharing of protected health information for the purposes or scheduling, marketing, and/or comprehensive care. I understand that I may revoke this authorization at any time by emailing compliance@herodvo.com.

_____ ____/____/_____

Patient Signature (or guardian if under 18) Date

Assignment of Benefits

- I authorize the practice to release necessary information, including but not limited to, examination, diagnosis, and treatment records, to third-party payors and/or other health practitioners.
- I authorize and request my insurance company to assign benefits and pay directly to the practice those insurance benefits otherwise payable to me.
- I understand that my insurance carrier may pay less than the actual bill for services.
- I authorize the use of my signature on all insurance submissions.
- I agree to be responsible for payment of all services rendered to me or the patient listed above.

_____ ____/____/_____

Patient Signature (or guardian if under 18) Date

Consent for Contact

By providing a telephone number (landline or cellular) or other wireless device, I agree that in order for the practice to service my account(s) (including contacting me about appointment reminders, surveys, obtaining potential financial assistance for my account(s), or to collect any amounts I may owe, the practice may contact me at the telephone number(s) provided which could result in charges to me. I expressly consent that methods of contact may include SMS text messages and phone calls. This consent applies to all services and billing associated with my account(s) and is not a condition of purchasing services. I understand that I may be contacted by various vendors used by the Practice. I understand that I must reply STOP to each form of text message I may receive to opt out of further text messages.

_____ ____/____/_____

Patient Signature (or guardian if under 18) Date

To the best of my knowledge, the questions on this form have been accurately answered.

_____ _____ ___/___/____

Printed Name Patient Signature (or guardian if a minor) Date