

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

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

Physician(s)	Patient Physician: _____	City, State: _____
	Last seen: _____	Reason for visit: _____
		Last physical: _____
	OtherPhysicians/Healthcareproviders: _____	City, State: _____
	Reason for care: _____	
	OtherPhysicians/Healthcareproviders: _____	City, State: _____
	Reason for care: _____	

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 _____

Notice of Privacy

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 of 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

Information Sharing

- 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

Assignment of Benefits

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

Consent for Contact

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