PATIENT REGISTRATION **DATE:________________________**

FIRST NAME:_______________________MI:____________LAST NAME:___________________________

ADDRESS:____________________________CITY:______________________STATE_______ZIP_________

HOME PHONE:____________________CELL:______________________ DOB:___________________

AGE:__________________ SOCIAL SECURITY:______________________ SEX: ____MALE ____FEMALE

EMPLOYER NAME:___________________________________ PHONE:______________________

PREFERRED PHARMACY & PHONE:____

PERSON RESPONSIBLE FOR ACCOUNT (IF SOMEONE OTHER THAN PAITENT OR IF PATIENT IS A CHILD)

____RELATIONSHIP:___________________________

ADDRESS IF DIFFERENT FROM PATIENT:____

PRIMARY INSURANCE INFORMATION

NAME OF INSURED:____________________________________RELATIONSHIP:_____________________

INSURED DOB:____________________ INSURED SOCIALSECURITYNUMBER:_______________________

INSURANCE COMPANY:____ID#:_____________________

GROUP #:___________________________________INSURANCE PHONE #:_________________________

INSURED EMPLOYER:_____________________________________

SECONDARY INSURANCE INFORMATION

NAME OF INSURED:____________________________________RELATIONSHIP:_____________________

INSURED DOB:____________________ INSURED SOCIALSECURITYNUMBER:_______________________

INSURANCE COMPANY:____ID#:_____________________

GROUP #:___________________________________INSURANCE PHONE #:_________________________

INSURED EMPLOYER____________________________________

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PATIENT NAME:____

ADDRESS:____

Which of the following communications means are appropriate/acceptable for MFD to communicate with you (please check all that apply)

Home phone ________________________ Ok to leave a message? _______YES _______NO

Cell phone ________________________ Ok to leave a message? _______YES _______NO

Work phone ________________________ Ok to leave a message? _______YES _______NO

Which method of communication is preferred? _____No contact_____Mail____Phone____Email

With whom may we share information about your Dental care? PLEASE LIST BELOW

Note: In order for to disclose your private dental information, the representative listed must be able to provide (2) two forms of identification. 1. Last 4 of patient's SSN 2. Patient's DOB

AUTHORIZATION TO DISCLOSE DENTAL INFORMATION

Name	Relationship	Phone #	MAY DISCUSS TREATMENT	MAY DISCUSS BILLING
______	______	______	YES___NO____	YES___NO____
______	______	______	YES___NO____	YES___NO____

EMERGENCY CONTACT:

______	______	______	YES___NO____	YES___NO____

Do you have a legal document that states who will make decisions if you are unable?
_____yes _____no

If yes,
Name__________________________________Relationship__________________________

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's dental information.

Patient/Legal Representative
Signature:______________________________________Date:________________

AUTHORIZATIONS, ACKNOWLEDGEMENTS

PATIENT NAME:____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

*INITIAL HERE*_____________I ACKNOWLEDGE THAT A COPY OF THE NOTICE OF PRIVACY PRACTICES WAS MADE AVAILABLE TO ME.

GENERAL CONSENT TO TREATMENT

*INITIAL HERE*____________ I CONSENT TO EXAMINATION BY DR. BRELAND AND OTHER DENTAL PROFESSIONALS AT THIS CLINIC. I ALSO CONSENT TO ANY DENTAL PROCEDURES, X-RAY, LABORATORY TESTS OR OTHER DENTAL CARE SERVICES ORDERED BY THE DENTAL CARE TEAM. I UNDERSTAND THAT I MAY REFUSE SPECIFIC TREATMENTS OR PROCEDURES BY INFORMING THE DENTAL CARE TEAM.

RELEASE OF INFORMATION

*INITIAL HERE*__________I AUTHORIZE MAGNOLIA FAMILY DENTAL TO RELEASE ANY DENTAL INFORMATION NECESSARY TO PROCESS PAYMENT OF MY CLAIM.

COMMUNICATIONS REGARDING MY ACCOUNT

*INITIAL HERE*________I AGREE THAT THE FACILITY, MAGNOLIA FAMILY DENTAL OR ANY OTHER COLLECTION AGENCY OR AGENCIES RETAINED BY MAGNOLIA FAMILIY DENTISTRY TO COLLECT ANY MONEY THAT I OWE TO THE FACILITY. THEY MAY CONTACT ME BY TELEPHONE OR TEXT MESSAGE AT ANY NUMBER GIVEN BY ME. I UNDERSTAND THAT IF I DEFAULT ON PAYMENT THAT COLLECTION FEES AND/OR COURT COST COULD BE ADDED TO MY BALANCE.

DENTAL INSURANCE

*INITIAL HERE*________ON THE DAY OF YOUR APPOINTMENT, ALL INELIGIBLE MONIES WILL BE COLLECTED (DEDUCTIBLES, CO-PAYS, ETC). THESE MONIES ARE REQUIRED TO BE PAID BY THE PATIENT PER THE INSURANCE COMPANY. IF YOU DO NOT HAVE DENTAL INSURANCE YOU WILL BE EXPECTED TO PAY BEFORE ANY TREATMENT IS PROVIDED.

RESPONSIBILITY

*INITIAL HERE*________IT IS YOUR RESPONSILIBITY TO PROVIDE US WITH CORRECT INSURANCE INFORMATION. IT IS YOUR RESPONSIBILITY TO KNOW IF WE ARE COVERED BY YOUR INSURANCE CARRIER. WE WILL VERIFY AND FILE YOUR INSURANCE AS A COURTESY BUT YOU ARE ULITMATELY RESPONSIBLE FOR THE CHARGES INCURED.

I UNDERSTAND THAT IF MY INSURANCE DOES NOT PAY WITHIN 60 DAYS THAT I WILL BE BILLED FOR SERVICES.

____ ________________________

PATIENT/PARENT/LEGAL GUARDIAN AUTHORIZED TO SIGN FOR PATIENT DATE