RTP Cosmetic & Family Dentistry

Patient Registration

First Name: ____________________ Middle Initial: _______ Last Name: _______________________

Address: _____________________________________ Home Phone:(___)_______________________
City: _________________ State/Zip: ______________ Work Phone: (___) _____________________
Birth Date: _____________ Age: _________ Cell Phone: (___) ______________________

Sex: ○Male ○Female Marital Status: ____________ Social Security Number: _________________

Email address: _____________________________________

EMERGENCY CONTACT: __________________________ Phone Number: _____________________

How would you prefer to receive appointment reminders? Please choose one.
○Phone Call – If so, which number: ___________________ ○Email ○Text Message

How did you hear about our office? ____________________________________

Dental Insurance Information:

Person responsible for account: ____
Last name First name Initial

Relationship to patient:_______________ Date of Birth:____________ Soc. Sec. #:__________________

Responsible party's employer: _________________________ Business phone:_____________________

Insurance company: ________________________________ Phone number: ______________________

Group number: _________________________________ Patient ID: ___________________________

Responsible Party (If someone other than patient)

Name: _______________________________________Date of Birth: ____________________

Address: _______________________________________ SS#: __________________________
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Home #: ___________________ Work #: ____________________ Cell #: _____________________

Regarding HIPAA:

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you information about our privacy practices. By signing below, you are acknowledging you have reviewed a copy of our HIPAA privacy handout.

Signature: _____________________________________
Date: ________________________________