Fiddlehead Dental **Patient Registration Form**

Getting to know you

Date_____ Date of Birth _____ Female Male

Name_____ Social Security #_____

Preferred Name_____ Status: Married Single Other_____

Address_____ Employer_____

City/State/Zip_____ Occupation _____

Phone (Home)_____ (Cell)_____ Emergency Contact Name_____

(Work)_____ (Other)_____ Emergency Contact Phone_____

Email Address_____ Relationship to Contact_____

Primary Dental Insurance Information

Policy Holder's Name _____

Policy Holder's Date of Birth_____

Policy holder's SSN_____

Subscriber Number _____

Insurance Company_____

Group Number_____

Employer _____

Secondary Dental Insurance Information

Policy Holder's Name _____

Policy Holder's Date of Birth_____

Policy holder's SSN_____

Subscriber Number _____

Insurance Company _____

Group Number _____

Employer _____

HIPAA & Consents

I give permission for the following individuals to contact Fiddlehead Dental regarding my dental appointments, treatment, and finances:_____

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by a doctor to make a thorough diagnosis of dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide care. ** Please Initial _____

I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. ** Please Initial _____

I understand that you bill my insurance as a courtesy to me, and that you do everything possible to help me utilize my insurance. I am aware that I am responsible for the whole amount if my insurance company fails to reimburse within eight weeks of treatment, or any charges my insurance does not cover. ** Please Initial _____

I agree to the following form of communication regarding treatment and payment: **Please initial any that apply

Email _____ Text _____

Patient/ Responsible Party Signature _____