PATIENT REGISTRATION - *Confidential*

Charles R. Fields DMD, PC

vers. 06/15

Date _____

Name: ◊ Dr. ◊ Mr. ◊ Mrs. ◊ Miss ◊ Ms. _____ (first) (init.) (last)

Address:

_____ (street) (apt# if any) (city) (state) (zip)

Date of Birth: (month /day / year) _____**Your Social Security Number**: _____--____--_____

Home Phone: ( ) _____ **Email** _____

Work Phone: ( )_____ **Mobile** ( )_____

Employer: _____ **Occupation**:_____

Spouse's / Parent's / Guardian's Name: _____

Spouse's / Parent's / Guardian's contact Phone Number: ( )_____

Emergency contact name and number: _____( )_____

*** OFFICE INSURANCE POLICY ***

We subscribe to a limited number of insurance plans. Routine insurance submissions are performed as a courtesy to you. However, an administrative fee will apply for complicated / excessive insurance processing.. We do not submit medical insurance claims. **We do require proof of insurance in order to develop and process any insurance claim.**

Insurance info*:* ***Subscriber Name**:*
Subscriber SS#:
***Subscriber Date of Birth**:*

OFFICE PRIVACY POLICY

Our office always attempts to protect the privacy of our patients. We comply with all federal (HIPAA), state and local regulations, where applicable. A copy of our privacy policy is available online and is posted in the waiting room for public viewing. Information regarding your care is **only** shared as a professional necessity as it relates to your care; no information is shared for any other reason.

I comprehend English, and acknowledge that I have seen and/or received a copy of the office's privacy policy. I understand that all communication with me, or healthcare providers, will be sent securely, to the extent possible.

_____ _____

Seen Privacy Policy and **kept a copy** *(Signature)* *Seen Privacy Policy and* **returned the copy** *(Signature)*