PATIENT REGISTRATION

Date: _____

First Name: _____**Last Name**: _____Middle Initial: _____

Responsible Party (if someone other than the patient)
First Name: _____Last Name: _____Middle Initial: _____
Address: _____ Address 2: _____
City, State, Zip: _____
Home Phone: _____Work Phone: _____Ext: _____ Cell Phone: _____
Birthdate: _____ Soc Sec: _____ Drivers Lic: _____
⎔ Responsible Party is also a Policy Holder for Patient ⎔ Primary Insurance Policy Holder ⎔ Secondary Policy Holder

Patient Information
Address: _____Address 2: _____
City, State, Zip: _____
Home Phone: _____Work Phone: _____Ext: _____ Cell Phone: _____
Birthdate: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____
Sex: ⎔ Male ⎔ Female Marital Status: ⎔ Married ⎔ Single ⎔ Divorced ⎔ Separated ⎔ Widowed
E-Mail: _____ ⎔ I would like to receive correspondences via e-mail

Insurance Information
Primary Insurance
Name of Insured: _____Patient Relationship to Insured ⎔ Self ⎔ Spouse ⎔ Child ⎔ Other
Insured Soc. Sec. or ID Number: _____ Insured Date of Birth: _____
Employer of Insured: _____Insurance Company: _____
Insurance Company Address: _____City, State, Zip: _____
Secondary Insurance
Name of Insured: _____Patient Relationship to Insured ⎔ Self ⎔ Spouse ⎔ Child ⎔ Other
Insured Soc. Sec. or ID Number: _____ Insured Date of Birth: _____
Employer of Insured: _____Insurance Company: _____
Insurance Company Address: _____City, State, Zip: _____
*We may ask to take a photo copy of your insurance card

Electronic and Telephone Communication Confidentiality Waiver
It is sometimes necessary to communicate with you as a patient by means other than a controlled office environment. These modes of communications can include: email, text messaging, telephone conversations, messages left on voicemail and instant messaging services. By signing and dating below, you as the patient of Pacific Avenue Dental PC understand that I cannot guarantee your confidentiality when such modes of communication are implemented. Although modern security measures are taken by email service provider, landline or cellular phone companies and internet service provider, neither they nor I can guarantee that your information cannot be accessed by unintended parties. Please be aware of this fact when communicating by such modes and keep your software and hardware security tools up to date. It is also important to be aware of the environment in which you choose to communicate by such means and to password protect your computer. By signing, you have read and understand the statement about and release Martin E Burbano, DMD and Pacific Avenue Dental PC from liability resulting in loss of confidentiality when using such communication modes listed above.
Signature of Patient, Parent, or Guardian: _____

Receipt of Privacy Practices
I have received a copy of this office's Notice of Privacy Practices.
Printed Name: _____
Signature of Patient, Parent, or Guardian: _____

Do you have records that you would like transferred from another dental office? ⎔ yes ⎔ no
If yes, please provide the following information and signature for the records release form.
Previous Dentist's Name: _____ Phone number: _____
I hereby authorize the release of my dental records (X-rays, Perio Charting & Treatment Notes) to the following;
Martin E. Burbano, DMD, PC, 1818 Pacific Avenue, Forest Grove, OR 97116 or email to: info@padentalclinic.com
Phone: 503-992-2287 Fax: 503-992-2412
Patient Name: _____
Signature of Patient, Parent, or Guardian: _____