

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: _____ <input type="checkbox"/> Responsible Party is also a Policy Holder for Patient <input type="checkbox"/> Primary Insurance Policy Holder <input type="checkbox"/> Secondary Policy Holder
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Patient Information Address: _____ Address 2: _____ City, State, Zip: _____ Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____ Birthdate: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed E-Mail: _____ <input type="checkbox"/> I would like to receive correspondences via e-mail

Insurance Information Primary Insurance Name of Insured: _____ Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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

<i>Electronic and Telephone Communication Confidentiality Waiver</i> 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: _____
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<i>Receipt of Privacy Practices</i> I have received a copy of this office's Notice of Privacy Practices. Printed Name: _____ Signature of Patient, Parent, or Guardian: _____
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Do you have records that you would like transferred from another dental office? <input type="checkbox"/> yes <input type="checkbox"/> 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: _____
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