



Patient Registration

Date ____/____/____

Last Name _____ First Name _____ MI _____
Preferred Name _____ Gender: Male _____ Female _____
Address _____
City _____ State _____ Zip _____
Date of Birth ____/____/____ Age _____ Married _____ Single _____ Minor _____
Social Security No. _____ - _____ - _____ Driver's License No. _____
Phone: Home (____) _____ Business (____) _____ Cell (____) _____
E-mail address _____

Occupation _____ Employer _____
Business Address _____

Full-time students: School _____ City _____ State _____

If Married: Spouse's/Partner's Name _____ Date of Birth _____
Business Phone (____) _____ Social Security No. _____ - _____ - _____
Occupation _____ Employer _____
Business Address _____

Is another member of your family or relative a patient here at our practice? Yes ___ No ___
Name _____ Relationship _____
Whom may we thank for introducing you to our practice? _____
Person to contact in an emergency _____
Relationship to Patient _____ Home (____) _____ Business (____) _____

Dental Insurance Information

Primary Carrier _____
Carrier Address _____
Carrier Phone No. (____) _____ Group No. _____
Policy Holder _____ Date of Birth _____
Policy Holder's Address _____
Policy Holder's Phone No. (____) _____ Social Security No. _____ - _____ - _____

Insurance Authorization/Responsible Party

I hereby authorize this dental office to release to my insurer any information necessary to obtain benefits on insurance claims for me, my spouse or my dependents. I hereby authorize payment of my dental benefits, otherwise payable to me, to this office. I understand that I am financially responsible for all charges whether or not paid by insurance within 60 days after treatment has been rendered.

Signature of Insured/Responsible Party _____ Date _____



ESTHETIC EVALUATION

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. If you are completely satisfied with the appearance of your teeth and smile there is no need to fill out this form.

Name: _____ Date: _____

Please circle the answer that best suits you.

- | | | |
|---|------------|-----------|
| 1. Do you dislike the color of your teeth? | YES | NO |
| 2. Do you have spaces between your teeth that bother you? | YES | NO |
| 3. Do you have chips or uneven edges on your teeth? | YES | NO |
| 4. Do you feel your teeth are too long or too short? | YES | NO |
| 5. Do you have dark fillings that show when you smile? | YES | NO |
| 6. Do your gums show too much when you smile? | YES | NO |
| 7. Are your teeth too crooked or crowded? | YES | NO |
| 8. Do you have existing crowns or dental work that you consider “ugly”? | YES | NO |
| 9. Are you self-conscious of your teeth and/or smile? | YES | NO |
| 10. Has anyone (friend, family member, etc.) ever suggested that you should do something about your teeth or smile? | YES | NO |
| 11. Do you avoid smiling when you have your picture taken? | YES | NO |
| 12. Would you like to improve your existing smile? | YES | NO |
| 13. Do you wish you had a “new smile”? | YES | NO |

What concerns do you have regarding dental treatment to improve your smile?

1. Fear of treatment
2. Time of treatment concern
3. Financial concerns
4. Not understanding treatment
5. Embarrassment
6. Other _____

THANK YOU!



Patient Acknowledgement of Receipt of Dental Materials Fact Sheet
(This form must be downloaded separately from this packet of information.)

I, _____, acknowledge that I have received a
Patient Name (printed)
copy of the Dental Materials Fact Sheet (2001) from Anne Becker DDS.

Patient Signature

Date

Acknowledgement of Receipt of Privacy Practices Notice

This document acknowledges that you have received a copy of the Notice of Privacy Practices. This document is not a contract, authorization, release or consent form. This document will remain in your records.

I, _____, acknowledge that I have received a
Patient Name (printed)
copy of the Notice of Privacy Practices.

Patient signature

Date

If the patient is a minor, a parent or legal guardian must sign below:

Parent or Legal Guardian signature

Date

If the patient is not a minor but is under the care of a relative, friend, or caregiver, said person must sign here:

Parent or Legal Guardian signature

Date

Relationship to patient

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.

Certain Circumstances

Your protected health information can be disclosed without your written authorization in certain limited circumstances,

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information. *
- You have the right to request an alternate means or location to receive communications regarding your health information. *
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession. *
- You have the right to request in writing to restrict some of the uses and disclosures of your health information. *
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office. *

**Conditions and limitations may apply; obtain additional information from the front desk.*

Changes To This Notice: We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an update notice will be posted and a copy will be sent to you.