PATIENT REGISTRATION

(Please print)

Name _____
(Last, First, Middle) Nickname
Address _____

City _____ State _____ Zip _____

Phone _____ / _____ / _____ Soc. Sec. # _____
Home Office Cell

Date of Birth _____ Present Age _____ ○ Male ○ Female

○ Married ○ Single ○ Divorced ○ Separated ○ Widowed ○

Minor Occupation _____ Employer _____ Since _____

Employer's Address _____
Street City

Spouse _____ Soc. Sec. # _____ Date of Birth _____

Occupation _____ Employer _____ Since _____

Employer's Address _____

E-mail address _____

Person Responsible For Account (If different from above)

Name _____ Relationship _____
Address _____ Soc. Sec. # _____
Occupation _____ Employer _____ Since _____

Insurance Group #

Primary _____
_____

Secondary _____
_____

In Case of Emergency Contact

Name of nearest relative _____ Relationship _____
Address _____ Phone _____
_____

Who Referred You To Our Office

Name _____ Relationship _____
Address _____

Patient Dental History

What is your Primary Dental concern or reason for today's visit? _____
Have you had dental X-rays taken in the past 12 months? ○ Yes ○ No

_____
Date of your last dental visit: _____

Authorization, Terms & Conditions

I grant authority to the Dentist to perform procedures and treatment, including administration of medicine, local and general anesthetics, and extractions along with other surgical and dental procedures that may be necessary. I have received (or have been offered) a copy of this office's Notice of Privacy Practices and "The Dental Materials Fact Sheet". By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. If your insurance carrier does not remit payment within 60 days, the balance will be due and payable by you. Please have your completed insurance claim form with you at the first visit.

AUTHORIZED SIGNATURE _____ Date _____
Witness Initials _____

Assignment of Benefits Form

I hereby assign all dental benefits, to which I am entitled, to Dr. Sean Sunyoto. I authorize and direct my insurance carrier(s) to issue payment checks directly to Dr. Sean Sunyoto for dental services rendered to myself and/or my dependents. I understand that I am financially responsible for all charges not covered by insurance.

Authorization for Release of Information:

I authorize Dr. Sean Sunyoto to:

1. Release any necessary information to my insurance carriers regarding my treatment.
2. Process insurance claims generated during my examination or treatment.
3. Use my signature on all insurance submissions for a lifetime, unless I revoke this authorization in writing.
4. I understand that by requesting dental services from Dr. Sean Sunyoto, I am responsible for all charges incurred, whether or not they are covered by insurance. I agree to pay any outstanding balance upon presentation of a statement.

A photocopy of this form shall be considered as valid as the original.

Notice of Privacy Practices Acknowledgment (HIPAA):

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have rights to privacy regarding my protected health information. I acknowledge that I have been informed of Dr. Sean Sunyoto's Notice of Privacy Practices, which outlines how my health information may be used and disclosed.

I understand that:

This information may be used to conduct and manage my treatment, obtain payment from third-party payers, and carry out normal healthcare operations.
I can request a copy of the Notice of Privacy Practices at any time.

I may request restrictions on how my health information is used or disclosed, but Dr. Sean Sunyoto is not required to agree to these restrictions unless they are legally obligated to do so.

Patient Signature: _____

Date: _____