Hugh D. Burke Jr., D.D.S. Inc.

Patient Registration

Patient's Name _____ Date of Birth _____ □ Male □ Female
Last First Initial

If Child: Parent's Name _____

Whom may we thank for this referral _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Fax _____ E-Mail _____

Patient/Parent Employed By _____ Spouse Employed By _____

Patient/Parent Social Security No. _____ Spouse/Parent Social Security No. _____

Who is Responsible for this account _____ Drivers License No. _____

Purpose of Call _____ Other Family Members in this Practice _____

Someone to notify in case of emergency not living with you _____

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Insurance Company _____ Group/Policy # _____

Name of Subscriber _____ Social Security # _____

Street address _____

City _____ State _____ Zip _____

Date of Birth _____ Employer _____

SECONDARY DENTAL INSURANCE INFORMATION:

Name of Insurance Company _____ Group/Policy # _____

Name of Subscriber _____ Social Security # _____

Street address _____

City _____ State _____ Zip _____

Date of Birth _____ Employer _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

By signing below I acknowledge that I have received and reviewed a copy of Notice of Privacy Practices and I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment of payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

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