Waikiki DENTAL

TERESA HALL, DDS

ALOHA!!!

NEW PATIENT REGISTRATION

ABOUT YOU

NAME: _____ LAST _____ FIRST _____ MI

I PREFER TO BE CALLED _____

BIRTHDATE: _____ AGE: _____ SS#: _____

☐ Single ☐ Married ☐ Student School: _____

HOME ADDRESS: _____

_____ City _____ State _____ Zip

HOME PHONE: _____ CELL PH: _____

WORK PHONE: _____ EXT: _____

Email: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

WHEN/ WHERE BEST TO REACH YOU: _____

REASON FOR APPOINTMENT: _____

FINANCIAL INFORMATION

NAME: _____

_____ (email)

WORK PH. _____ EXT _____ HOME

BILLING ADDRESS:

_____

RELATIONSHIP: _____

EMPLOYER: _____

DL#: _____

SPOUSE INFORMATION

(PARENT OR GUARDIAN IF PATIENT IS A MINOR)

NAME: _____

EMPLOYER: _____

WORK PH#: _____ EXT: _____ SS#: _____

BIRTHDATE: _____ DL#: _____

EMERGENCY CONTACT

NAME: _____

RELATION: _____

WORK PH#: _____

HOME#: _____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

EMPLOYEE'S NAME: _____

EMPLOYEE'S S.S.#: _____

EMPLOYEE'S BIRTHDATE: _____

RELATION TO PATIENT: _____

INSURANCE CO: _____

GROUP #: _____

INSURED'S EMPLOYER: _____

SECONDARY INSURANCE

EMPLOYEE'S NAME: _____

EMPLOYEE'S S.S.#: _____

EMPLOYEE'S BIRTHDATE: _____

RELATION TO PATIENT: _____

INSURANCE CO: _____

GROUP #: _____

INSURED'S EMPLOYER: _____

HOW DID YOU BECOME OUR PATIENT

☐ BUILDING SIGN

☐ LOCAL PROMOTION

☐ PERSONAL/ PROFESSIONAL REFERRAL*

☐ Other _____

* Is there someone we should thank for referring you to our practice? If so who:

_____

NOTICE OF PRIVACY PRACTICES

I have read and understand the copy of Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____