

PATIENT REGISTRATION

Name _____

Address _____

Tel. No. Home _____ Work _____ Cell _____

Email address _____

Birth date. _____ Soc.Sec.# _____

Your Employer _____

Your Dental Benefits Plan _____

Your Spouse/Partner's Name _____ -

(2nd) Dental Benifits _____ Please give cards to scan

Soc. Sec. # _____

Birth date _____

Their Employer _____

In case of emergency notify: _____ Phone # _____

What brings you in to see us? _____

Questions you would like to ask?

Who may we thank for your referral? _____

The staff will go over your heath history in private. We ask that the information you give them, be accurate and true.

Signature: _____ -

_____ Date _____ -

Dr. Richard Herbert, D.M.D., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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