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)

_____

_____

_____