BEACH DENTISTRY

Patient Registration

Today's date_____ Patient LAST NAME_____ FIRST _____ MI _____
How do you wish to be addressed?_____Date of Birth _____ SSN _____
Address _____ City _____ State _____ Zip_____
Telephone (home) _____ Telephone (cell)_____Telephone (work) _____
Email _____ Who can we thank for referring you to our office? _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name	Subscriber Name
Subscriber ID	Subscriber ID
Date of Birth	Date of Birth
Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other	Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other
Employer Name	Employer Name
Employer Phone	Employer Phone
Insurance Company	Insurance Company
Insurance Group	Insurance Group
Insurance Phone	Insurance Phone

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY *(If minor)*

Last Name:_____ First: _____ Initial:____
Address *(If different)* _____ Date of Birth _____
City _____ State _____ Zip _____
Telephone (Home)_____ (Work)_____ (Mobile) _____
Email _____

EMERGENCY CONTACT

Last Name:_____ First: _____ Initial:____
Telephone (☐Mobile ☐Work ☐Home) _____

Authorization

I consent to any necessary diagnostic procedures and dental treatment, including the administration of local anesthetics when indicated. I consent to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to this dental office. I understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance.

I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment, and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time.

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

Patient Signature _____ Date _____