PATIENT REGISTRATION

David P. Fishberg, D.M.D., P.A.

Patient Information

Name: _____ Home Phone: _____
Last First Middle Initial Cell Phone: _____
Address: _____ Email: _____

_____
City State Zip

Birth Date: _____/_____/_____ ☐Single ☐Married ☐Partnered ☐Minor
M D Y

SS#: _____ Sex: ☐M ☐F ☐Widowed ☐Divorced ☐Separated

Employer: _____ Present Position: _____ How long held?: ___

Business Address: _____ Business Phone: _____

If college student - School name: _____ Full Time Student: Yes / No

Spouse / Partner name / If child, parent's name: _____ Birth Date: _____/_____/_____
M D Y

Person responsible for this account: _____

In the event of an emergency who should be notified?: _____

Relation to Patient: _____ Home Phone: _____ Cell Phone: _____

Purpose of this appointment?: _____

Whom may we thank for referring you?: _____

Your Signature: _____ Today's Date: ___/___/___
M D Y

Primary Insurance

Name of Insured: _____ Relation to Patient: _____
Last First Middle Initial

Address: _____ Home Phone: _____
(If different from above) Cell Phone: _____

_____ Email: _____
City State Zip

Insured's Birth Date: _____/_____/_____ Insured's SS#: _____
M D Y Insured's Sex : ☐M ☐F

Employer: _____ Business Phone: _____

Business Address: _____

Insurance Company: _____

Group #: _____ Subscriber #: _____

Secondary Insurance

Name of Insured: _____ Relation to Patient: _____
Last First Middle Initial

Address: _____ Home Phone: _____
(If different from above) Cell Phone: _____

_____ Email: _____
City State Zip

Insured's Birth Date: _____/_____/_____ Insured's SS#: _____
M D Y Insured's Sex : ☐M ☐F

Employer: _____ Business Phone: _____

Business Address: _____

Insurance Company: _____

Group #: _____ Subscriber #: _____

Authorization for Signature on File

Release of Information/Financial Responsibility/Authorization for Payment/Assignment

I, _____ and/or _____ hereby authorize the office of
Name of Patient (Parent or Guardian if Minor) Name of Insured
David P. Fishberg, D.M.D., P.A. to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with _____. I hereby
Employer
assign and authorize payment of dental benefits otherwise payable to me, directly to the office listed above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim.

This "Authorization" will be valid from this date and shall remain valid until revoked in writing. A photocopy of this document may act as an original.

_____ _____
Signature of Insured Witnessed By

_____ _____
Signature of Patient (Parent or Guardian if Minor) Today's Date

Acknowledgment of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

I, _____ have received a copy of David P. Fishberg, D.M.D., P.A.'s Notice
Your Name
of Private Practices.

_____
Print Name

_____
Signature

_____
Date

For Office Use Only

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

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

_____

_____

_____