

**PATIENT REGISTRATION**

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_

Out of Town Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Out of Town Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_ Referred by: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

Marital Status: S \_\_ M \_\_ D \_\_ W \_\_ Person Responsible for Account: \_\_\_\_\_

Dental Insurance: Yes \_\_\_ No \_\_\_ Pharmacy Phone # \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I understand that, under the Health Insurance Portability & accountability Act 1996 ("HIPPA") I have certain rights to privacy regarding my protected health information., I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and in indirectly.

Obtain payment to be paid to me from third-party payers (Insurance Companies) as per my request.

Palm Beach Prosthodontics, LLC. It's associated and staff have permission to leave a message on my home answering machine and/or to call me at my place of work unless I direct them not to do so in writing.

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please review our Notice of Privacy Practices , the privacy of your health information is important to us.