

# Kuras Dental Health Associates

## REGISTRATION FORM

<b>Office Use Only:</b>		Today's Date:		Employee Name:	
<b>PATIENT INFORMATION (Please Print)</b>					
Patient's Last Name:			<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.		Marital status <b>(circle one)</b>
First:		Middle:		<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	
Single / Mar / Div / Sep / Wid		Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name? Birth Date:	
Sex:		Age:		S.S. #	
<input type="checkbox"/> M <input type="checkbox"/> F					
Street address:			Cell Phone #: (   )		
			Home Phone #: (   )		
P.O. Box:		City:		State:	
				ZIP Code:	
Occupation:		Employer:		Employer Phone #:	
				(   )	
Referred to office/doctor by (please check one box):		<input type="checkbox"/> Dr. <input type="checkbox"/> Close to home/work		<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital	
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other: _____			
Other family members seen here:					
<b>INSURANCE INFORMATION</b>					
<b>(Please give your insurance card to the receptionist.)</b>					
Person responsible for bill:		Address (if different):		Home Phone #:	
Birth Date:   /   /		Street:		(   )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No		City/State/Zip:		S. S. #:   -   -	
Occupation:		Employer Address:			
Employer:		Employer Phone #: (   )			
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Primary Insurance:			
Subscriber's Name:		Birth Date:   /   /		Group #:	
Subscriber's S. S. #:		Policy #:			
Patient's relationship to subscriber:		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Name of Secondary Insurance (if applicable):			Subscriber's Name:		
Group #:			Policy #:		
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			Subscriber's S.S. #:   -   -		
<b>IN CASE OF EMERGENCY</b>					
Name of local friend or relative <b>(not living at same address):</b>			Home Phone #: (   )		
Relationship to Patient:			Work Phone #: (   )		
<p><b>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance that may acquire on my account. I also authorize Kuras Dental Health Associates or my insurance company to release any information required to process my claims.</b></p> <p><b>I confirm that I have been informed of my rights to privacy regarding my protected health information, the Health Insurance Portability and Accountability Act (HIPPA). I have been given and reviewed a copy of the detailed Notice of Privacy Practices. This information may be used to coordinate treatment, obtain payment and conduct normal health care operations and assessments.</b></p>					
Patient/Guardian Signature:			Date:		
_____			_____		