

Patient Registration Form

Account # _____ Update # _____ New Patient # _____

PATIENT _____ Male/Female _____

Last First MI

Date of Birth ____ / ____ / ____ Age ____ Social Security _____

Home Address (NO PO BOX) _____

City _____ State _____ Zip _____

Home Phone () _____ Pager () _____

FAX () _____ Cell () _____

E-Mail _____

Employer Info _____ Business # () _____

Occupation _____

Business Address _____

Spouse Information _____ Date of Birth ____ / ____ / ____

SSN _____ Employed by _____

Business # _____ Occupation _____

Referring Doctor or Person _____

EMERGENCY CONTACT (Name of Relative or Friend, not living with you)

Name _____ Relationship _____

Address _____ Phone () _____

PRIMARY INSURANCE

No Insurance []

Insurance Carrier _____ Phone () _____

Address _____

Insurance ID _____ Group/Plan _____

Name of Insured _____

Patient's Relationship to Insured _____ Self _____ Spouse _____ Child _____

Amount of your Co-pay \$ _____

I, _____ authorize Jack Von Bulow, DDS to examine and provide medical treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to Jack Von Bulow, DDS. I authorize Jack Von Bulow, DDS to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments and specialists and specialist providers which are assigned to me according to my insurance policy rule. It is Jack Von Bulow, DDS's procedure to share Protected Health Information with labs, x-rays, consulting physicians and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Patient or Responsible Party Signature

Date