GKG Gina K. Garner DDS, PC

EXCELLENCE IN DENTISTRY

Patient Registration Information

Patient Information

Patient First Name:_____ Middle Initial: ___ Patient Last Name: _____

Nickname:_____ Date of Birth___/___/_____ Sex: (circle) M/ F Social Security #:_____-_____-_____

Street Address:_____ Apt #:_____

City & State:_____ Zip Code:_____ Email:_____

Home Phone : (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

Marital Status: (Please Circle) Married Single Divorced Separated Widowed

Emergency Contact Name:_____ Phone Number:_____

How did you hear about our office?:_____

Responsible Party Information (If Different From Patient)

First Name:_____Middle Initial: ___ Last Name: _____

Date of Birth___/___/_____ Sex: (circle) M/ F Social Security #:_____-_____-_____

Street Address:_____ Apt #:_____

City & State:_____ Zip Code:_____ Email:_____

Home Phone : (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

Privacy Information

Please let us know how you would like to be contacted regarding your dental health and appointment information:

1. Please circle how we may contact you. (Circle as many that apply.) Home Number, Work Number, Cell Number
2. May we leave messages regarding your dental health and appointments at these numbers? (Circle) Yes No
3. May we contact you via the email address you provided us? (Circle) Yes No

Patient Consent

Please Initial

_____

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you and for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. This practice provides this form to comply with the Health Insurance Portability and Account of 1996 (HIPAA). The patient/ guarantor understands:

- *Protected health information may be disclosed or used for treatment, payment or health care options.*
- *The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.*
- *The practice reserves the right to change the Notice of Privacy Policies*
- *The patient may revoke this Consent in writing at any time and all future disclosures will then cease.*

Assignment And Release

Your initials and signature acknowledge your understanding of the Privacy and Patient Consent sections on this form. Your signature also authorizes Gina K. Garner DDS, PC to release medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when an assigned claim is filed. “I authorize that any benefits due be paid directly to my dentist. I also understand payment is expected at the time of service (all copays and balances must be paid when service is given.”

_____ Patient Signature

_____ Parent Signature (if patient is a minor)

_____ Date