NC PROSTHODONTIC SPECIALISTS

7201 Creedmoor Road , Suite 120
Raleigh, NC 27613
Phone (919) 846- 6622 /Fax (919) 846 - 8012

PATIENT REGISTRATION FORM

Patient's Name _____ Date ____/____/____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Minor (under 18 years)

Social Security # _____ Birthdate ____/____/____

Phone (Home) _____ (Work) _____ Ext. _____ (Cell) _____

Address _____ / _____
Street City State Zip Email Address (optional)

Employer Name _____ Occupation _____

Emergency Contact _____ Phone Number _____

Relationship to Patient _____

What is the reason for your visit? _____

_____

Whom may we thank for referring you to our dental office? _____

RELEASE FOR TREATMENT

I authorize the dental office of NC Prosthodontic Specialists (Dr. Bill Scruggs, Dr. Anthony Molina & Dr. Anthony Gragg) and any other agents or employees as selected by them to treat me. This treatment may require the administration of local and/or general anesthetics (EXCEPT for _____ _____ due to an allergic reaction). Although these anesthetics are used for my benefit, they may occasionally cause inflammation, allergic reaction, pain, nerve damage because of anatomic variations, fainting and high and/or low blood pressure.

I also authorize the dental office of NC Prosthodontic Specialists to photograph me for use in educational and teaching purposes only. ***NO PHOTOS will be posted on any social media and/or other forms of internet networking and/or public venues without written consent by the patient.***

Signature _____ Date _____

Print Name: _____

Patient Registration Form completed by patient? ☐ Yes ☐ No
If no, please explain the relationship to the patient _____

_____

RESPONSIBLE PARTY INFORMATION

Name: _____

Social Security Number: _____ **Birthdate** ____/____/____

Phone: (home) _____ (work) _____ (Ext.) (Cell) _____

Address: _____
Street City State Zip Code

INSURANCE INFORMATION

****Please be advised, we are a Medicare opt out facility. No provided services will be filed for Medicare reimbursement.**

Name of insured subscriber _____

Relationship to patient ☐ Self ☐ Spouse ☐ Other _____

Please complete if different from patient information

Address _____
Street City Zip Code

Phone (Home) _____ (Work) _____ Ext._____ (Cell) _____

Social Security or ID # _____ Birthdate ____/____/____

Employer _____ Phone Number _____

Primary Dental Insurance

Company _____ Insurance Phone # _____

Address _____ Group # _____

_____
City State Zip Code

Secondary Insurance

Subscriber's Name _____ SSN # _____

Company _____ Insurance Phone # _____

Address _____ Group # _____

_____
City State Zip Code

I authorize the dental office of NC Prosthodontic Specialists, to release information relating to my dental treatment whenever necessary. Upon my request, they will submit a pre-determination of insurance benefits for treatment. Once my dental treatment is completed, as a courtesy by NC Prosthodontic Specialists, they will submit a dental insurance claim form on my behalf to my insurance carrier. Thereafter, the insurance payment will be sent directly to me. I understand that I am responsible for all costs of my dental treatment and that payment is due and payable according to financial agreements made in this dental office.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES – HIPAA

I _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in the office policy.

I understand this consent and acknowledgement shall remain in force indefinitely.

☐ I do not give my consent to acknowledge the agreement set forth in the HIPAA information form. _____
Initial

Signature _____ Date _____