

Patrick J. McCoy DDS

Patient Registration

Patient Information

Patient _____
 Address _____
 City _____ State _____ Zip _____
 Sex: M F Age _____ DOB _____
 Single Married Widowed Divorced
 Patient/Guardian SSN _____
 Occupation _____
 Employer _____
 Spouse's Name _____
 DOB _____ SS# _____
 Employer _____
 Whom may we thank for referring you? _____

Phone Numbers:

Cell _____ Cell Carrier(text) _____
 Home _____ Work _____
 Email _____
Reminder via: () Home () Cell () Work () Text () Email
 Emergency contact _____
 Relationship to you _____
 Home _____ Cell _____

Financial Responsibility/Dental Insurance

Subscriber _____
 DOB _____ Relationship to patient _____
 Ins ID# or SS# _____
 Insurance Co. _____ Group# _____
 Ins. Phone _____ Employer _____
 Is patient covered by other insurance? No () Yes () If Yes:
 Subscriber _____
 DOB _____ Relationship to patient _____
 INS ID# or SS# _____
 Insurance Co. _____ Group# _____
 Ins. Phone _____ Employer _____

Assignment and Release

I certify that I (or my dependent) have insurance coverage and assign directly to Patrick J. McCoy, DDS all insurance benefits, if any, for services rendered. *I understand that I am financially responsible for all charges whether or not paid by insurance.* I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____

Date _____

Acknowledgement of Privacy Practices and Cancellation Policy

I acknowledge that I have been offered a copy of the Statement of Privacy Practices for the office of Patrick J. McCoy, DDS. The Statement of Privacy Practices describes uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office healthcare operations. The posted Statement of Privacy Practices describes my rights and the responsibilities of this office with respect to my protected health information.

Patrick J. McCoy, DDS reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If changes occur I will be offered a revised copy at the first visit after the revision is made.

Additional Disclosure

In addition to the allowable disclosures described I authorize disclosure of my protected health information to the persons indicated below.

Any member of my immediate family Spouse only Other _____

Print Patient Name _____ Patient Signature _____

Guardian Signature if Minor _____

This office has a 48 business hour cancellation policy. If you miss or late cancel your scheduled dental appointment you will be charged a \$50 fee per appointment.

Signature _____ Relationship _____ Date _____