Patient Registration **Brodhead Dental Clinic**

Patient Information (please fill out all sections)

- First Name: _____ (Preferred Name: _____)
- Last Name: _____
- Date of Birth: _____
- Address: _____
- Telephone Number: _____
    - Phone Type (circle one) CELL/HOME/WORK
- Email: _____
- Social Security Number: _____
- Employer/Occupation (if applicable): _____
- Dental Insurance Company and Member Number (if applicable)

  _____

Privacy/HIPAA Notice

- I acknowledge that I have received a copy of the Privacy Policy from the Brodhead Dental Clinic.
- I acknowledge that the above information is correct

Patient or Guardian Signature: _____
Printed Name: _____
Relationship to Patient: _____
Date: _____

Office Use Only
I attest that a good faith effort was made to obtain the information and signature on this form.
Staff Signature: _____ Date: _____
The patient would not complete and sign because (circle one):

1. Communication Barriers 2. Emergency Situation 3. Patient Refuses to Sign 4. Other: _____