Patient Registration

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Daniel P. Rooke, DMD
FAMILY DENTISTRY

Patient Registration

Please take a moment to fill out this Information in order to ensure that we have the most current information for you and be able to provide you with the best service possible.

PATIENT LAST NAME *

PATIENT FIRST NAME *

MI

Preferred Name

BIRTH DATE *

__/__/____

AGE *

GENDER *

○ M ○ F

MARITAL STATUS *

○ Single ○ Married ○ Separated ○ Divorced ○ Widowed ○ Child ○ Other

RESIDENCE Street *

City *

State *

Please select

Zip Code *

_____

MAILING ADDRESS Street

City

State

Please select

Zip Code

_____

PHONE #'S Home

(___) ___-____

Work

(___) ___-____

Ext

Pager/Cell *

(___) ___-____

E-MAIL *

EMPLOYER

DRIVER'S LICENSE # *

Who may we thank for referring you to our office? *

IS THE PATIENT THE RESPONSIBLE PARTY? *

○ YES ○ NO

RESPONSIBLE PARTY INFORMATION

LAST NAME *

FIRST NAME *

MI

Preferred Name

BIRTH DATE *

__/__/____

AGE *

GENDER *

○ M ○ F

MARITAL STATUS *

○ Single ○ Married ○ Separated ○ Divorced ○ Widowed ○ Child ○ Other

RESIDENCE Street *

City *

State *

Please select

Zip Code *

_____

MAILING ADDRESS Street

City

State

Please select

Zip Code

_____

PHONE #'S Home *

(___) ___-____

Work

(___) ___-____

Pager/Cell

(___) ___-____

Ext

E-MAIL *

EMPLOYER

DRIVER'S LICENSE # *

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RESPONSIBLE PARTY'S SPOUSE

LAST NAME | FIRST NAME | MI

BIRTH DATE | EMPLOYER

PHONE #'S Home | Work | Pager/Cell

Ext

EMERGENCY INFORMATION
(Relative not living with you)

NAME * | Relationship * | Phone Number *

ADDRESS * | CITY/STATE *

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DENTAL INSURANCE (PRIMARY)

Insured's Name | Insurance Co. | Insurance Co. Phone Number

Address

Insured's Employer

Insured's SS# | Birth Date

Insured's ID # | Insured's Group #

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name | Insurance Co.

Address

Insured's Employer

Insured's ID #

Birth Date

__/__/____

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HIPPA PRIVACY POLICIES

We are required by law to maintain the privacy of, and provide individuals with, notice of our legal duties and privacy practices with respect to protected health information, By signing below you acknowledge that you have been offered a copy of the federal HIPPA privacy practices.

Initials *

Also, for accounting/bookkeeping purposes, I agree to allow Dr. Daniel P. Rooke, DMD list information regarding all family members' dental services or account information on one statement.

Initials *

PATIENTS WITH INSURANCE FINANCIAL RESPONSIBILITY AGREEMENT

I,

Initials *

understand that, although I have assigned insurance• benefits to this office, my insurance company will pay claims based on a fee schedule negotiated between my employer and the insurance company, assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid The dental fees incurred. I further understand that it is very possible that there may be a balance remaining after my claims have been paid and that it is my responsibility to pay that balance upon the next billing date.

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated.

Signature *

Today's Date

05/08/2024