Ithaca Dentistry

Patient Registration

Date_____ (please print) Home Phone (____) _____

Patient Name Last_____ First_____ M.I.____ Preferred_____

Street Address _____ City_____ State_____ Zip_____

E-mail_____ Cell Phone (____) _____

Sex ___M ___F Age_____ Birthdate_____ ___Married ___Widowed ___Single ___Minor

___Separated ___Divorced ___Partnered for ____ Years

Employer/School_____ Occupation_____

Employer/School Address_____ Employer/School Phone (____) _____

Spouse/Parent Name_____ Spouse/Parent Employed by_____

Who is responsible for this account? _____ Relationship to Patient_____

Are you currently under the care of another dentist? yes/no Name_____

In case of emergency, who should be notified?_____ Phone (____)_____

Who may we thank for referring you? _____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I have received and understand the Notice of privacy Practices. The notice provides in detail the uses and the disclosures of my protected health information that may be made by this practice, individual rights, how I may exercise these rights and the practice's legal duties with respect to my information. I understand that the practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. If changes of the policy occur, this practice will provide me a revised Notice of Privacy Practices upon my request.

_____ _____

Signature of patient or parent (if minor) Date