Metuchen Dentistry
652 Middlesex Ave
Metuchen, NJ, 08840
Phone: (732) 603-0030
Fax: (732) 603-8255

PLEASE PRESENT PHOTO ID

Patient Registration

Name: _____ Preferred Name: _____

Birthdate: _____/_____/_____ SS#: _____ Male/Female: _____

Address: _____ City/State/Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

If Under 18: Parent/Guardian: _____

Address/Phone of Parent/Guardian if different than above:

Emergency Contact:
Name: _____ Relationship: _____ Phone: _____

DENTAL INSURANCE INFORMATION- PLEASE PRESENT CARD UPON ARRIVAL

Primary Dental Insurance

Name of Subscriber: _____ Relationship to Patient: _____

Birthday: ____/_____/_____SS#: _____ Employer: _____

Insurance Company: _____ Phone Number: _____

Insurance Company Address: _____

Group #: _____ Member ID: _____

Secondary Dental Insurance

Name of Subscriber: _____ Relationship to Patient: _____

Birthday: ____/_____/_____SS#: _____ Employer: _____

Insurance Company: _____ Phone Number: _____

Insurance Company Address: _____

Group #: _____ Member ID: _____

REFERRAL INFORMATION

How did you hear about our practice? _____

Akata Patel, DMD
652 Middlesex Ave
Metuchen, NJ, 08840
Phone: (732) 603-0030
Fax: (732) 603-8255

PLEASE READ AND SIGN 3 TIMES BELOW RELATING TO OUR HIPAA PRIVACY INFORMATION

ACKNOWLEDGEMENT OF PRIVACY/SECURITY RULE

I ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF THE HIPAA PRIVACY PRACTICE/SECURITY RULE. I UNDERSTAND THAT MY PROTECTED HEALTH INFORMATION WILL NOT BE SOLD FOR MARKETING OR RESEARCH PURPOSES AND I HAVE THE RIGHT TO OBTAIN A COPY OF MY PROTECTED HEALTH INFORMATION.

1)_____ DATE: _____ /_____/_____
SIGNATURE OF PATIENT/PARENT (IF PATIENT IS A MINOR, PLEASE PRINT CHILD'S NAME NEXT TO SIGNATURE)

AUTHORIZATION AND RELEASE

I AUTHORIZE DR. AKATA PATEL AND/OR HER STAFF TO RELEASE INFORMATION, WITH MY CONSENT, INCLUDING THE DIAGNOSIS AND/OR RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD, TO DENTAL OR MEDICAL INSURANCE COMPANIES OR OTHER DENTAL HEALTHCARE PROVIDERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR MY SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

2)_____ DATE: _____ /_____/_____
SIGNATURE OF PATIENT/PARENT (IF PATIENT IS A MINOR, PLEASE PRINT CHILD'S NAME NEXT TO SIGNATURE)

CONSENT TO TREAT

I AUTHORIZE DENTAL TREATMENT DISCUSSED WITH ME TO BE PERFORMED BY DR. AKATA PATEL AND/OR HER STAFF.

3)_____ DATE: _____ /_____/_____
SIGNATURE OF PATIENT/PARENT (IF PATIENT IS A MINOR, PLEASE PRINT CHILD'S NAME NEXT TO SIGNATURE)

IF NECESSARY, I AUTHORIZE THE SHARING OF MY INFORMATION WITH:

NAME	RELATIONSHIP	PHONE	PATIENT INITIALS