MICHAEL C. HERREN, DMD

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION:

Date: ______________________ Family Doctor: ______________________

Name: ______________________ Date of Birth: __________ Age: ____ Sex: M ☐ F ☐

Address: ______________ City: __________ State: ______ Zip code: __________

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ **Social Security #** ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

INSURANCE INFORMATION:

Primary Insurance Company: ______________________________________

Subscribers Name: ______________________ Subscribers Date of Birth: ______________

Subscribers Social Security Number: ______________

Secondary Insurance Company: ______________________________________

Subscribers Name: ______________________ Subscribers Date of Birth: ______________

Subscribers Social Security Number: ______________

Your insurance is an agreement between the insurance company and the insured. We can only give you an estimation of benefits. YOU are responsible for deductibles and charges not covered by your plan.

EMERGENCY CONTACT INFORMATION:

Name: ______________________ Relationship: ______________ Phone: ______________

DENTAL HISTORY:

Former Dentist: ______________________ City, State: ______________________

Date of last visit: ______________________ Last X-rays: ______________________

How often do you brush? ______________ Floss? ______________________

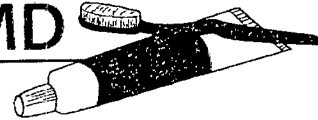
I have read the above statement and understand that *I am responsible for any remaining balance that my insurance does not pay.*

I authorize payment directly to Dr. Michael C. Herren, DMD, for all insurance benefits otherwise payable to me for services rendered on my behalf or my dependents.

I authorize the above provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: ______________________ Date: ______________________

Chris Herren DMD
Family Dentistry



AUTHORIZATION FOR EMAIL/TEXT APPOINTMENT REMINDERS

I, ______________________________, authorize Michael C. Herren, DMD, to send appointment reminders electronically via Email or Text Message to the following:

Email: ______________________________

Mobile #: ______________________________

I understand that text service is offered free of charge; however, standard text messaging rates from my mobile carrier may apply.

Email reminder will come from YourDentalOffice@citywatchonline.com.

Patient Name: ______________________ Date: ____________

Patient Signature: ______________________________

Parent/Legal Guardian Signature: ______________________________

Michael C. Herren, DMD ***Rebecca Vawter, DMD***

1221 West 5th Street | London, KY 40741 | Phone 606.864.4744 | Fax 606.878.7235
michaelherrendmd@windstream.net

Chris Herren DMD

Family Dentistry

CONSENT/HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (ie: my insurance company)
- The day-to-day operation of your practice (id: recall post cards that include date and time of appointment)

I understand that I have the right to review and secure a copy of you *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that your reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operation, but that you are not required to agree to these requested restrictions; however, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time; however, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: ______________________________

Name: ______________________________

Relationship to patient: ______________________________

Signature: ______________________________

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