KIENE DENTAL GROUP
Family, Cosmetic, & Laser Dentistry

Registration

(Please Print)

PATIENT INFORMATION

Patient Last Name:	First:	M.I.:	❑ Mr. ❑ Dr.	❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Preferred Name:			❑ Male ❑ Female		Date of Birth: _____ / _____ / _____ (Month) (Date) (Year)
Street address:			Social Security:		Drivers License:
P.O. box or Apt #:	City:		State:		ZIP Code:
Email:			Home Phone:		Cell Phone:
Occupation:	Employer:				Employer phone: ( )

Employment Status: ❑ Full-time ❑ Part-time ❑ Retired Student Status: ❑ Full-time ❑ Part-time

Contact Preferences: ❑ Text ❑ Email ❑ Cell Phone ❑ Home Phone ❑ Work Phone

In addition to a one-week reminder, would you like a 24-hour advance courtesy reminder? ❑ Yes ❑ No

Referred to Kiene Dental Group by: (Person): _____ ❑ Insurance ❑ Website

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other _____

Other family members seen here:

❑ Primary Insurance Policy Holder ❑ Secondary Insurance Policy Holder

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone: ( )	Work phone: ( )
Cell Phone:	Email:		

RESPONSIBLE PARTY (If other than patient)

Responsible Party Last Name:	First:	M.I.:	❑ Mr. ❑ Dr.	❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street address:			Social Security:		Drivers License:
P.O. box or Apt #:	City:		State:		ZIP Code:
Email:			Home Phone:		Cell Phone:
Occupation:	Employer:				Employer phone: ( )

❑ Primary Insurance Policy Holder ❑ Secondary Insurance Policy Holder

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Insurance

Patient Name: _____ **Date:** _____

(Please Print)

PRIMARY INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Subscriber's name:		Subscriber's Social Security:	Birth date: / /	
Subscriber's Address: (if different than patient's)		City:	State, Zip:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				
Is Subscriber a patient here? ❑ Yes ❑ No		Occupation:		
Employer:	Employer Address:	Employer City, ST, Zip:	Employer Phone no.:	
Dental Insurance Company:	Dental Insurance Address:	Insurance City, ST, Zip:	Insurance Phone no.:	
Employee Cert/Policy no.:	Group no.:	Co-payment/Deductible:	Remaining Deductible:	Rem Benefits:

SECONDARY INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	
Subscriber's Address: (if different than patient's)		City:	State, Zip:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				
Is Subscriber a patient here? ❑ Yes ❑ No		Occupation:		
Employer:	Employer Address:	Employer City, ST, Zip:	Employer Phone no.:	
Dental Insurance Company:	Dental Insurance Address:	Insurance City, ST, Zip:	Insurance Phone no.:	
Employee Cert/Policy no.:	Group no.:	Co-payment/Deductible:	Remaining Deductible:	Remaining Benefits:

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Authorization

AUTHORIZATION FOR TREATMENT

I give my authorization to the dentists and team members of Kiene Dental Group to render dental treatment to me that they judge to be beneficial to my oral and overall health. In giving this authorization it is understood that my dental condition will be explained to me and options for treatment of said dental condition will be explained with pros and cons of each treatment option.

It is further understood that I have the right to refuse any treatment option presented. However, with refusal of treatment, it is understood that the dentists at Kiene Dental Group have the option to refuse future treatment and even dismiss me from the practice when such refusal of treatment is seen as detrimental to my future dental health, or compromises the professional ethics of the dentist.

_____
Initial

NOTICE OF PRIVACY PRACTICES AND PRACTICE POLICY

I have been given to read and review, if requested by me, the Notice of Privacy Practices followed by Kiene Dental Group as well as the Kiene Dental Group Practice Policies.

_____
Initial

INFORMATION RELEASE

I give my permission for my medical and personal information including the diagnosis and the records of any treatment or examination rendered to be shared with the following individuals on my behalf:

_____ _____
Person's Name Relationship to Patient

_____ _____
Person's Name Relationship to Patient

_____ _____
Person's Name Relationship to Patient

I authorize Kiene Dental Group to release medical or personal information identifying me when pertinent with other Dental or Medical Professionals with whom we are referring care as well as insurance carriers for the purpose of claims submitted for my account.

_____
Initial

FINANCIAL RESPONSIBILITY AND INSURANCE

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____
Initial

SIGNAURES (*Please initial above and sign below*)

_____
Patient Name (Print)

_____ _____
Signature **Date**

_____ _____
Responsible Party Name (for minor) **Relationship to Patient**

_____ _____
Signature of Responsible Party **Date**