AMOSKEAG URGENT DENTAL CARE

REGISTRATION FORM

Patient's Last Name ______________________ Patient's First Name ________________________

Has your information changed such as phone number or address since we last saw you?_____, If yes please provide new information. ____

HOW DID YOU HEAR ABOUT US? ____

I hereby authorize and request the performance of dental services for myself and/or dependent. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by Dr. Salem/Associates and staff for diagnostic purposes or dental treatment. I also hereby authorize to conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

I further agree that any dispute about the reasonableness or computation of the fees, or any claim of negligent or intentional acts or omissions in the rendering of professional services, either in this specific instance or in any other treatment rendered by staff in this office, shall be submitted to binding arbitration to the American Arbitration Association, National Futures Association or Internet-Arbitration. It is understood by both doctors and patient that by agreeing to submit all claims or assertions that either patient or doctor may have against the other arising out of this agreement patient and doctors have given up their right to a jury or a court trial.

I UNDERSTAND AND ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR THE SERVICED RENDERED, REGARDLESS OF INSURANCE COVERAGE. I hereby authorize payment directly to the aforementioned dentist/dental office for dental benefits otherwise payable to me.

*Are you interested in applying for financing? Yes No

NOTICE OF PRIVACY PRACTICES ACKNOWLEDEMENT

I understand that, under the Health Insurance Portability & Accountability of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Obtain payment from third-party payers.

*Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME (please print): ____

RELATIONSHIP TO (CHILD) PATIENT : ____

SIGNATURE: ____

Date: ____________________