ROBERT M. KELSO D.D.S., P.C.
Family And Cosmetic Dentistry

REGISTRATION FORM
(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Dr. ❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security #:	Home phone #: ( ) Cell Phone#: ( ) Email address:			
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone #: ( )				
Referred by:		❑ Website	❑ Dr.			
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other		
Other family members seen here:						

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone #: ( )		
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:	Employer phone #: ( )		
Is this patient covered by dental insurance? ❑ Yes ❑ No	If yes, please give name of Insurance Co.:				
Subscriber's name:	Subscriber's ID#:	Birth date: / /	Group #:	Policy #:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

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

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Robert M. Kelso, D.D.S. I understand that I am financially responsible for any balance. I also authorize Robert M. Kelso, D.D.S. or my insurance company to release any information required to process my claims.
Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

_____ _____

Patient/Guardian signature *Date*

Sign on Back

Robert M. Kelso, D.D.S., P.C.

HIPAA Compliance and Patient Consent

Patient HIPAA Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about patients to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take the minimum necessary information to only those we feel are in need of our health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you, such as laboratories that only interact with dentists and not patients, and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain your personal consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

Consent to Treatment

1. The undersigned here authorizes Dr. Kelso to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Kelso to make a thorough diagnosis of the patient's dental needs.

2. I also authorize Dr. Kelso to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Dr. Kelso choose and employ such qualified assistance as deemed fit to provide recommended treatment.

Patient: _____ Date: _____

Parent or Responsible Party: _____ Relationship to Patient: _____