STEPHEN L. RUCHLIN, D.D.S.
GENERAL & COSMETIC DENTISTRY

Patient Registration

Patient Information:

Full Name: _____

Street, City, State, Zip: _____

Home Phone: _____ Cell Phone:_____

Email Address: _____ Can We email you? Yes/ No

Patient Date of Birth: _____ Driver's License Number: _____Sex: (circle) M F

Emergency Contact and Phone: _____

Insurance Information:

Do you have Dental Insurance? Yes No	Do you have a 2nd Dental Insurance? Yes No
Subscribers Name: _____	Subscribers Name: _____
Dental Insurance company:_____	Dental Insurance company:_____
Subscriber's Employer:_____	Subscriber's Employer:_____
Birthdate:_____	Birthdate:_____
Insurance ID Number: _____	Insurance ID Number: _____

Responsible Party (if someone other than the patient)

Full Name: _____

Street, City, State, Zip: _____

Phone Number: _____Birth Date: _____

Stephen L. Ruchlin D.D.S.

377 White Spruce Blvd.

Rochester, NY 14623

(585)427-7820

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____authorize Dr. Stephen L. Ruchlin's office to disclose information to _____ (Spouse, Partner, Family member, Friend)

Telephone number: _____

Disclose all Information: _____

I, undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

To the party receiving this information:

This information has been disclosed to you from records whose, confidentiality is protected by federal law. The Health Insurance Portability and Accountability act of 1996, as amended from time to time "HIPAA". This regulation prohibits you from making any further disclosures of information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

_____ _____

Patient's Signature Date

_____ _____

Signature of Parent, Guardian or Authorized representative Date

_____ _____

Witness Date