Nick J. McHargue, D.D.S., P.C.

3301 Broadway Business Park Court Suite C - Columbia, MO 65203 - (573) 445-3630

PATIENT REGISTRATION

Name _____ Preferred Name (if different) _____ Sex: M / F
First MI Last

Birthdate_____ Social Security No. _____ E-Mail_____

Address _____ City _____ State _____ Zip_____

Cell Ph. _____ Home Ph. _____ Status: Single / Married / Divorced / Separated / Widowed

Student Status: Full-time / Part-time / N.A.

Employer_____ Occupation_____ Work Phone _____ Ext._____

General Physician_____ Phone_____ Pharmacy Name_____ Phone_____

Emergency Contact (*not* living with you)_____Cell Ph._____ Home Ph._____

Address_____

How did you hear about us?_____

RESPONSIBLE PARTY **(If patient is the responsible party, please just fill-in the additional information not listed above.)**

Name _____Relationship to Patient_____
First MI Last

Birthdate _____ Social Security No. _____ Driver's License_____

Cell Ph. _____ Home Ph._____

Employer _____ Work Phone _____ Ext._____

Spouse Name_____
First MI Last

Spouse Employer _____ Work Phone _____ Ext._____

***CONSENT*: I consent to the diagnostic procedures and treatment by Nick J. McHargue, DDS, PC necessary for proper dental care.**

_____
Signature of Patient (for patients 17 yrs. or younger, parent or guardian *MUST* sign).

DENTAL INSURANCE **(Primary Insurance)**

Subscriber Name _____
First MI Last

Birthdate _____ SSN *or* Member ID _____

Employer _____ Group No. _____

Insurance Co _____ Phone No. _____

(Secondary Insurance)

Subscriber Name _____
First MI Last

Birthdate _____ SSN *or* Member ID _____

Employer _____ Group No. _____

Insurance Co _____ Phone No. _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient understands and agrees to allow Nick J. McHargue, DDS, PC to use her/his Patient Health Information for the purpose of treatment, payment, health care operations and coordination of care. Patient can be assured that Nick J. McHargue, DDS, PC does not sell Personal Health Information of any kind to a third party for such party's own use. Nick J. McHargue, DDS, PC wants you to know how your Patient Health Information is going to be used, and rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of our Patient Health Information, before signing this consent we encourage you to read our "Notice of Privacy Practices," which is available to you at the front desk. I received or have waived my right to a copy of Nick J, McHargue, DDS, PC's Notice of Privacy Practices.

_____
Signature of Patient (For patients 17 yrs. of age or younger, parent or guardian should sign.)

I authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself:

_____ _____
Please Print Name & Relationship Please Print Name & Relationship