Colby Family Smiles
4001 Colby Ave Suite A
Everett, WA 98201
(425) 252-8919
ColbyFamilySmiles.com

Adult Patient Registration

Today's Date _____

First _____ M. _____ Last _____

Address _____

Cell# _____ Home# _____

Work _____ DOB _____ SS# _____

Marital Status _____ Email _____

Employer _____ Occupation _____

Who may we thank for referring you? _____

Dental Insurance

Company _____ ID# _____

Subscriber Name _____ Sub Relationship to Patient _____

Sub Birth date _____ Employer _____

Sub SS# _____ Group# _____

Sub Address _____

Emergency Information

Name of nearest relative not living with you _____

Relationship to patient _____ Cell# _____

Address _____

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the statement of Privacy Practices for the offices of Chelsea D. Mortell Petisme. The statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The statement of Privacy Practices also describes my rights and the responsibilities and duties of the office with respect to my protected health information. Dr. Chelsea D. Mortell Petisme reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If they change I will be offered a copy of the revision and may request that it be mailed to me.

I herby specifically authorize disclosure of my protected health care information to the persons indicated: _____

I have filled in my information to the best of my ability and understand that it will be used to bill my dental insurance and to acknowledge receipt of the Notice of Privacy Practices.

Signature _____ **Printed Name** _____