Tech Initials:
Follow Up Date:
In Office Reveal Notes:

REVEAL DIAGNOSTICS

REGISTRATION FORM

(Please Print)

Referring Dentist:			**Office Location:**
First Name:			**Last Name:**
Date of Birth:	**Sex:** **Female** **Male**		**For Female Patients ONLY:** **Any Chance of Pregnancy? YES / NO**
Street Number or P.O. Box:			
City:	**State:**	**ZIP Code:**	**Phone Number:**

IF REFERRING DENTAL OFFICE IS COVERING THE COST OF SERVICE PLEASE SKIP THIS SECTION

Email is used to send receipt &/or Dental Claim form ONLY
Email:

REVEAL DOES NOT PROCESS INSURANCE- A claim form will be emailed to you.
Check this box if you would like a Dental Claim Form ☐

Flexible Spending Account/Health Savings Account/Insurance: Itemized Receipt: YES / NO

CONSENT & RELEASE

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMTION

I consent to allow Reveal Diagnostics to use and disclose my **HEALTH INFORMATION** in order to carry out treatment and healthcare operations.

By signing this form, I am consenting to Reveal Diagnostics use and disclosure of my information as detailed above. However, I may give notice to restrict the use of such information and revoke my consent in writing. I understand that I have the right to review the **NOTICE OF PRIVACY PRACTICES** for a more complete description of such uses and disclosures prior to signing the consent.

FINANCIAL RESPONSIBILTY

I accept financial responsibility for all charges for my examination and will pay at the time of service. I understand that I will have to submit my own claim form to insurance for reimbursement.

X_____ _____
Signature of Patient or Legal Guardian Date