PATIENT REGISTRATION

PATIENT INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Birthdate: _____ Social Security Number: _____ Email: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employer: _____ Occupation: _____

Referred By: ☐ Family/Friend: _____ ☐ Google ☐ Facebook ☐ Mail Piece

☐ Yellow Pages ☐ Insurance Company ☐ Other: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

Preferred Pharmacy: _____

Comments: _____

RESPONSIBLE PARTY: Patient is: ☐ Responsible Party

First Name: _____ Last Name: _____ Middle Initial: _____

Relation to patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Birthdate: _____ Social Security Number: _____ Email: _____

Employer: _____ Occupation: _____

PRIMARY INSURANCE INFORMATION:

Dental Insurance Company: _____

ID Number/Member ID: _____

Policy Holder Name: _____

Policy Holder Birthdate: _____

Policy Holder's SSN: _____

Policy Holder's Employer: _____

Policy Holder's Address: _____

Policy Holder's Zip Code: _____

SECONDARY INSURANCE INFORMATION:

Dental Insurance Company: _____

ID Number/Member ID: _____

Policy Holder Name: _____

Policy Holder Birthdate: _____

Policy Holder's SSN: _____

Policy Holder's Employer: _____

Policy Holder's Address: _____

Policy Holder's Zip Code: _____

<u>In Office Signatures:</u>

I have read and understand the Notice of Privacy Practices and Authorization (HIPPA).

Signature: _____ Date: _____

Relationship to patient: _____

I give my consent to Successful Smiles to notify/contact me via unencrypted email or text which may include personal health information. (ex: appointment reminders, notifications)

Signature: _____ Date: _____

Relationship to patient: _____

SUCCESSFUL SMILES