

# 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: \_\_\_\_\_

### In Office Signatures:

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: \_\_\_\_\_

