I Smile Dentistry

REGISTRATION FORM

Today's Date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:		Home phone no.: ( )
City:	State:	ZIP Code:	Cell Phone: ( )

Occupation:	Employer:	Employer phone no.: ( )

How did you hear about our office? Please check your answer	☐ Friend	☐ Insurance plan	☐ Internet
☐ Family ☐ Zocdoc	☐ Close to home/work ☐Other	Can we leave a message on any of the above phone numbers?	☐ Yes ☐ No
Other family members seen here:	Email:		

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )
Is this person a patient here? ☐ Yes ☐ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ☐ Yes ☐ No	Insurance name:		

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	ID#

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

In the event of an emergency please contact:

Name ______________________________ Relationship ______________Phone________________________

Name ______________________________ Relationship ______________ Phone________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize I Smile Dentistry to release any information required to process my claims.

Patient/Guardian signature ______________________ _Date_ ______________