Smith Dental Care

Patient Registration Form

Welcome to Our Practice!

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. First Name: _____ M.I. ____ Last Name: _____

Sex: ☐ Male ☐ Female Birthdate: _____ Age: _____ Soc. Sec. #: _____

Street: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Referred By: _____ Payment Type: ☐ Cash ☐ Check ☐ Credit Card

License or State ID #: _____ Have you ever been to our practice? ☐ Yes ☐ No

Has a family member ever been to our practice? ☐ Yes ☐ No

Spouse or Other Guarantor Information

First Name: _____ Last Name: _____ Relation: _____

Birthdate: _____ Soc. Sec. #: _____ Phone #: _____

Street: _____ City: _____ State: _____ Zip: _____

Insurance Information

Student: ☐ Full Time ☐ Part Time ☐ None

☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Single

Employed: ☐ Full Time ☐ Part Time ☐ Retired ☐ None

School: _____ Employer: _____

Primary Dental Insurance

Employer: _____

Ins. Co. Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Group #: _____

Sub ID #: _____

Insured Party: _____

Relation: _____

Secondary Dental Insurance

Employer: _____

Ins. Co. Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Group #: _____

Sub ID #: _____

Insured Party: _____

Relation: _____

Your insurance policy is a contract made between you and your insurance company. We will attempt to give you the closest estimated cost for treatment based on the information we receive from you and your insurance company, but cannot guarantee any payment on their behalf. We are happy to submit your dental claims through insurance for you, but ultimately you will be responsible for any unpaid balances.

Assignment of Benefits

I authorize that I and/or the guarantor listed above are responsible for full payment of dental benefits to Smith Dental Care, P.A. for any and all dental services rendered.

Release of Information

I authorize Smith Dental Care, P.A. to release all dental information necessary to process dental insurance claims.

By signing below you are authorizing "Assignment of Benefits" and, if you provided insurance information above, "Release of Information".

Signature Or Signature of Parent/Guardian: