PATIENT REGISTRATION

Date: _____

Name: _____

(First Name) (Middle Name) (Last Name)

Preferred Name: _____ Marital Status: _____

Birthdate: _____ Social Security No.: _____

Address: _____ Apartment/Unit No.: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____

Employed By: _____ Occupation: _____ Work Phone: _____

Emergency Contact: _____ Phone No.: _____

Spouse Name or Parent if Minor: _____ Birthdate: _____

Phone Number: _____ Social Security No.: _____

Employed By: _____ Occupation: _____

Primary Dental Insurance Company: _____

Policy Holder Name: _____ Relationship to Patient: _____ Policy Holder Birthdate: _____

Policy Holder Soc. Sec/ID No.: _____ Policy Holder Employer: _____

Secondary Dental Insurance Company: _____

Policy Holder Name: _____ Relationship to Patient: _____ Policy Holder Birthdate: _____

Policy Holder Soc. Sec/ID No.: _____ Policy Holder Employer: _____

Who may we thank for referring you? _____

Mandatory Consent: I acknowledge that I have received a copy of Saving Smiles Dentistry's Privacy Practices. This notice describes how Saving Smiles Dentistry may use and disclose my health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

Signature: _____ Date: _____