

Smile Mantra Family Dentistry REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	Marital status (circle one)	
				<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	Preferred Name:	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Social Security no.:		Home phone: ()	Cell phone: ()			
Street Address:		City:	State:	Zip:		
Occupation:	Employer:		Employer phone: ()			
May we contact you at work, if necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Chose clinic because/Referred to clinic by (please check one box): <input type="checkbox"/> Dr. <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital						
<input type="checkbox"/> Family <input type="checkbox"/> Friend (name): <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other (please specify):						
Other family members seen here:						
Email Address:						
How would you like to receive reminders about your appointments? <input type="checkbox"/> Telephone <input type="checkbox"/> Email <input type="checkbox"/> Both						

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Financial Responsible Party's Full Name:		Birth date: / /	Main phone number: ()		
Address (if different):					
Occupation:		Employer:			
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name of primary insurance:					
Subscriber's name:	Subscriber's SSN or ID no.:		Birth date: / /	Group no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home/Cell phone no.: ()
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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 Smile Mantra Family Dentistry or insurance company to release any information required to process my claims.

PATIENT/GUARDIAN SIGNATURE	DATE
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