REGISTRATION FORM

(Please Print)

Today's Date:	Time:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	○Mr. ○Mrs.	○Miss ○Ms.	Marital Status (circle one) Single Mar Div Sep

Email Address:	Cell Phone # :	Birth Date:	Age:	Sex: ○Male ○Female

Street Address:	Social Security # :	Home phone # :

P.O. Box:	City:	State:	Zip Code:

Occupation:	Employer:	Employer Phone # :

○ Insurance Plan	**How did you hear about our office?**	○ Family/Friend

○ Google	○ Yelp	○ Close to home/work	○ Facebook ○ 1-800 Dentist	○ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to receptionist.)

Person responsible for bill:	Birth Date:	Address (If different) :	Home phone # :

Is this person a patient here? (circle one) Yes No

Occupation:	Employer:	Employer Phone # :

Is this patient covered by insurance? (circle one) Yes No

Please indicate primary insurance:	○ (insurance)	○ Welfare(please provide Coupon	○ Other

Subscribers name:	Subscriber's S.S # :	Birth Date:	Group # :	Policy #:

Patients relationship to subscriber:	○ Self	○ Spouse	○ Child	○ Other

Name of secondary insurance (if applicable) :	Subscriber Name :	Group # :	Policy # :

Patients relationship to subscriber	○ Self	○ Spouse	○ Child	○ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address) :	Relationship to patient:	Home phone # :	Work Phone # :

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand and am financially responsible for any balance. I authorize Smiles On Haymarket or insurance company to release any information required to pay my claims.

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Patient/Guardian Signature   Date