Smiles for the Future Pediatric Dentistry & Orthodontics

ADULT REGISTRATION FORM

Today's Date:_____

PATIENT'S NAME: _____**MIDDLE:** _____**M/F**_____ **DOB:**_____
FIRST AND LAST

ADDRESS: _____
STREET TOWN ZIP CODE

HOME# (____) _____ **WORK # (___)** _____**CELL# (___)**_____

MARRIED DIVORCED SINGLE SEPARATED DOMESTIC PARTNERSHIP (PLEASE CIRCLE)

EMPLOYER: _____ **OCCUPATION:** _____

EMERGENCY CONTACT (NOT LIVING WITH YOU) _____ **(____)** _____ _____
NAME PHONE RELATIONSHIP

HOW DID YOU HEAR ABOUT US? _____

PLEASE COMPLETE:

☐ NO DENTAL INSURANCE (**PAYMENT IS EXPECTED AT TIME OF SERVICE)**

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE (copy of card required to bill services)

Insured's Name: _____

Relationship to Patient: _____

Insurance Carrier: _____ _____

ID# _____ **Group#**_____

Carrier Ph#_____

Policy Effective Date:_____

ADDITIONAL INSURANCE (copy of card required to bill services)

Insured's Name:_____

Relationship to Patient _____

Insurance Carrier:_____

ID#:_____**Group #**_____

Carrier Ph#:_____

Policy Effective Date:_____

(Complete only if insured is different from the patient)

Employer:_____

Occupation:_____

DOB: _____

SS#:_____

Home#:_____**Work #**_____

Cell#_____

Employer:_____

Occupation:_____

DOB:_____

SS#:_____

Home#:_____**Work#**_____

Cell#_____

I hereby authorize Smiles for the Future Pediatric Dentistry and Orthodontics to submit a claim in an effort to obtain payment from my insurance carrier(s) for services rendered. I understand that the financial responsibility remains with me regardless of coverage.

Signature:_____