Patrick C. Smith DDS PA
13901 U. S. Highway One, Suite 9 Juno Beach 33408 * (561)694-9000

Med Alert
Drug interactions
Premed
Allergies

Patient Registration Form

Note: The information on this form is necessary for quality, comprehensive care. It is (of course) strictly confidential and in compliance with "HIPPA" The Health Insurance Patient Protection Act.
Please complete all parts, checking all areas and circling as appropriate.

Name: (Mr. Mrs. Ms. Dr.) _____ Marital Status: M/D/S/W Spouse Name:_____

Date of Birth: _____Age: _____ Home Phone# _____Cell # _____

Email Address: _____Drivers License_____ ***(Please give receptionist to copy)***

Florida Address: _____ City _____ Zip _____

Northern Address: _____ City _____ Zip _____

Residency: Permanent or Seasonal From: _____ To: _____

Employment Status: Full time _____ Part time ____ Student ___ School _____ Retired _____

Occupation: _____ Employer Name: _____

Employer Address: _____ Employer Phone # _____

Dental Insurance? _____ Insurance Company? _____Insurance provided by _____

Insurance company Address: _____ City _____ Zip _____

Phone # _____ Group # _____ ***(Please give receptionist to copy)***

Name and SS# of subscriber _____ Date of birth of subscriber _____

Relationship to Subscriber: **Self / Spouse / Child** Do you have secondary insurance? Yes/No

Reason for your visit today? _____

Whom may we thank for referring you to our dental office? _____

I certify that I have read and understand the above. I acknowledge that the questions set forth above have been answered to my satisfaction. I will not hold Dr. Smith or his staff responsible for any errors or omissions that I have made in the completion of this form. I am responsible for payment of all services rendered by this office regardless of insurance coverage.

Signature of Patient/***Responsible Party***: _____ Date: _____

Signature of Staff: _____ Date: _____