Patrick C. Smith DDS PA

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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

Date of Birth: _____Age: _____Social Security Number: _____

Cell # _____ Home Phone# _____

Email Address: _____ Driver's License State_____ ***(Please provide to office for record)***

Residency: Permanent or Seasonal From: _____ To: _____

Florida Address: _____ City _____ Zip _____

Northern Address: _____ City _____ Zip _____

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

Employer Name: _____ Employer Phone: _____

Employer Address: _____ City _____ Zip _____

Dental Insurance Company: _____ Insurance Individual/Employer_____

Insurance company Address: _____ City _____ Zip _____

Insurance Company Phone Number: _____

Subscriber Name: _____ Date of birth of Subscriber _____

Member#: _____ Group#: _____ ***(Please provide copy to office for record.)***

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: _____