HEALTHY SMILES FAMILY DENTISTRY
PATIENT REGISTRATION & DENTAL INSURANCE INFORMATION

First Name__________________ MI ____ Last Name ________________________ Preferred name_________

Date of Birth ________________ SS#___________________ Email __________________________________

Mailing Address _____________________________ City ______________________ ST_____ Zip_________

Phone- Home______________________ Work______________________ Cell__________________________

☐Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other ☐ Male ☐ Female ☐ Other

Employer ________________________________ Occupation ______________________________________

Who may we thank for referring you?____________________________ Preferred Pharmacy_______________

WHO IS RESPONSIBLE FOR THIS ACCOUNT (if other than self)?

Name of responsible party ____________________________________Relationship to patient _____________

Address ____________________________________ City ______________________ ST____Zip__________

Phone-Home _____________________ Work ______________________ Cell_________________________

Employer ________________________________ Occupation ______________________________________

DENTAL INSURANCE INFORMATION

Insured's Name _____________________________________ SS#__________________Birthdate_________

Insured's Employer _____________________________________work phone__________________________

Employer Address ____________________________ City _____________________ ST____Zip __________

Name of Insurance Company ___________________________________Phone_________________________

Subscriber ID#_________________________________ Group#____________________________

Insurance Company Address ____

By signing this document, I assign insurance payment to Healthy Smiles Family Dentistry for services provided to myself or a family member.

I understand that Healthy Smiles Family Dentistry may not be in-network or contracted with my dental insurance company and they will submit my dental claims as a courtesy to me.

I understand that I am responsible for all balances that are unpaid by the insurance company after contracted adjustments are completed.

Signature of Responsible Party __________________________________Today's Date ________________