Confidential Client Registration Information

Personal/Contact Information:

Mr.__ Mrs.__ Ms__ Miss__ Dr.__ Date (D/M/Y):_____
Surname:_____ First name:_____ Middle initial:_____
Preferred Name:_____ Gender: Female:__ Male:__ Birthday (D/M/Y):_____
Address:_____
Home phone_____ Cell phone: _____ Work phone:_____
Preferred daytime contact number: H___ C___W___ Email: _____
Employer:_____ Work address:_____
Family physician:_____ Phone:_____ Location:_____
Medical specialist:_____ Phone:_____ Location:_____
Emergency contact:_____ Relationship to patient: _____
Daytime phone:_____ Cell number: _____
If client is a minor or in custody/guardianship, who is responsible for the authorization of dental care:_____

Insurance Information:

Primary Dental Insurance Policy

Policy holder name:_____ Birthday (D/M/Y):_____
Relation to client:_____ Insurance company:_____
Insurance Co. address & phone: _____
Group/policy number:_____ Certificate/Div/ID#: _____
Basic coverage: _____% Insurance limit/yr:_____ Rolling/calander yr:_____

Secondary Dental Insurance Policy

Policy holder name:_____ Birthday (D/M/Y): _____
Relation to client:_____ Insurance company:_____
Insurance Co address & phone:_____
Group/policy number:_____ Certificate/Div/ID#:_____
Basic coverage:_____% Insurance limit/yr:_____ Rolling/calander yr:_____

Many dental insurance companies allow us submit insurance claims on your behalf. In order to do so we require your authorization. I authorize the release of information contained in claims to be submitted electronically to my dental benefits provider. I authorize the communication of information related to dental coverage and benefits to my dental insurance provider. If allowed, I assign my benefits payable from claims to be submitted electronically and authorize payment directly to the clinic Something To Smile About. I will be responsible for the payment of any remaining balance that my insurance provider does not cover.

Date:_____ Signature of Client/Parent/Gaurdian:_____