CONFIDENTIAL PATIENT INFORMATION (PLEASE PRINT IN CAPITAL LETTERS)

SMILEORA REGISTRATION FORM TODAY'S DATE _____

NAME _____ D.O.B _____
LAST NAME /FIRST NAME / MIDDLE

PREFERRD NAME_____SOCIAL SECURITY # _____

ADDRESS _____

_____CITY _____STATE _____ ZIP _____

HOME PHONE _____WORK PHONE_____EXT_____

CELL _____FAX_____PHARM # _____Best Time to Call_____

EMAIL ADDRESS _____REMINDER BY(Please Circle): E-MAIL MAIL

CHECK APPROPRIATE BOX: ☐MINOR ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐SEPARATED

PATIENT'S OR PARENT'S EMPLOYER _____

BUSINESS ADDRESS _____

_____CITY _____STATE _____ZIP _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

RESPONSIBLE PARENT(**PARENT OR GUARDIAN MUST FILL OUT THIS SECTION FOR MINORS UNDER AGE 18)**

NAME OF PERSON RESPONSIBLE _____RELATIONSHIP_____

ADDRESS _____

HOME PHONE _____SOCIAL SECURITY # _____ BIRTHDATE _____

EMPLOYER _____ WORK PHONE _____

INSURANCE PARTY

NAME OF INSURED _____ RELATIONSHIP _____

BIRTHDATE _____SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER (If different from above) _____

ADDRESS _____

_____CITY _____STATE _____ZIP _____

INSURANCE COMPANY _____ID # _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ YES ☐ NO **IF YES, COMPLETE THE FOLLOWING:**

NAME OF INSURED _____ RELATIONSHIP_____

BIRTHDATE _____ SS OR ID # _____ _____DATE EMPLOYED _____

NAME OF EMPLOYER (If different from above) _____

ADDRESS_____

_____CITY _____STATE _____ZIP _____

INSURANCE COMPANY _____ _____ID # _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information may result in legal action & I will be responsible for the same.

SIGNATURE OF THE PATIENT OR PARENT OF MINOR_____DATE_____