Center for Beautiful Smiles
FAMILY, COSMETIC & SEDATION DENTISTRY

Patient Registration

First Name: ______ Last Name: ______ Middle Initial: ______

Patient is: ☐ Policy Holder ☐ Responsible Party
Preferred Name: ______

Responsible Party (if someone other than patient)

First Name: ______ Last Name: ______ Middle Initial: ______
Address: ______ Address 2 ______
City, State, Zip: ______
Home Phone: ______ Work Phone: ______ Ext.: ______ Cellular: ______
Birthdate: ______ Social Security: ______ Driver's License: ______
Email: ______ ☐ I would like to receive email correspondence
☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Holder ☐ Secondary Insurance Holder

Patient Information

Address: ______ Address 2: ______
City, State, Zip: ______
Home Phone: ______ Work Phone: ______ Ext.: ______ Cellular: ______
Birthdate: ______ Age: ______ Social Security: ______ Driver's License: ______
Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single
Email: ______ ☐ I would like to receive email correspondence ☐ Text Reminders
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired
Employer: ______ Phone #: ______
College: ______ Units: ______
M.D.'s Name: ______ Phone #: ______
Kaiser Medical Record #: ______
Emergency Contact: ______
Contact Phone #: ______
Whom may we thank for referring you?
______

Primary Insurance Information

Name of Insured: ______ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Social Security: ______ Birthdate: ______ Insured ID # ______
Employer: ______
Address: ______
______
City, State, Zip: ______
Group #: ______
Insurance Company: ______
Address: ______
City, State, Zip: ______

Secondary Insurance Information

Name of Insured: ______ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Social Security: ______ Birthdate: ______ Insured ID # ______
Employer: ______
Address: ______
______
City, State, Zip: ______
Group #: ______
Insurance Company: ______
Address: ______
City, State, Zip: ______

Concerns

______
______
______
______

Would you like any referral to other health professionals? ☐ Yes ☐ No