SMITH & STAHR, PCS.

Patient Registration

Patient Information

Date:_____

Patient Name:_____
First Last Middle Initial

Preferred Name:_____

Patient Is: □ Policy Holder □ Responsible Party
□ Full Time Student

Address:_____
City:_____
State:_____ Zip:_____

Home Phone:(___)____-_____ Cellular:(___)____-_____

Work Phone:(___)____-_____ Ext:_____
□ I would like to receive corresponences via text.
Email:_____
□ I would like to receive correspondences via email.
Please indicate the best way the reach you.

□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Other

Birth Date:_____ Age:_____
Soc. Sec. #:_____
Drivers Lic:_____

Sex: □ Male □ Female

Patient Employer: _____

Spouse's Name:_____
Spouse's Phone #: (____)____-_____
Spouse's Email:_____

In case of Emergency, contact:
Name:_____
Relationship:_____
Daytime Phone:(____)____-_____

Whom may we thank for referring you?

_____

Responsible Party Information

(if different from patient)

Name:_____
First Last Middle Initial
Address:_____
City:_____
State:_____ Zip:_____
Home Phone:(___)____-_____ Cellular:(___)____ -_____
Work Phone:(____)____-_____ Ext:_____
Birth Date:_____ Age:_____
Soc. Sec. #:_____
Drivers Lic.:_____

Dental Insurance

Policy Holder's Name:_____
Relationship to Patient:_____
Birth Date:_____Soc.Sec.#:_____
Employer:_____
Insurance Co.:_____
Group #:_____
Member ID:_____
Is Patient covered by additional insurance? □Yes □No
Secondary Insurance Co.:_____
Policy Holder's Name:_____
Relationship to Patient:_____
Birth Date:_____Soc.Sec.#:_____
Employer_____
Group #_____
Member ID:_____

Assignment and Release for Insurance

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

HIPAA

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I have received a copy of the Notice of Privacy Practice (HIPAA).

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please Print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient