Perfect Family & Cosmetic Dentistry Smiles

Welcome

Southcoast Smiles

Patient Registration Form

Today's Date

Patient Name _____ Preferred Name _____

Birth date _____ Age _____ Sex ☐ M ☐ F

SS# _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address _____

City _____ State _____ Zip Code _____

Email Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____

Person Responsible for Account (If other than patient)

Name _____ SS# _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____

Emergency Contact

Name _____ Relationship _____

Address _____ Phone _____

How did you hear about our office?

☐ Billboard ☐ Brochure ☐ Postcard ☐ Radio ☐ Website

Friend (please specify) _____

Other (please speciy) _____

Referring Dentist or Orthodontist name _____

Dental Insurance - Primary

Insured's Name _____

Insured's DOB _____

Insured's SS# _____

Ins. Co. Name _____

Ins. Co. Phone # _____

Group # _____

ID # _____

Dental Insurance - Secondary

Insured's Name _____

Insured's DOB _____

Insured's SS # _____

Ins. Co. Name _____

Ins. Co. Phone # _____

Group # _____

ID # _____

Dental History

What would you like us to do today? _____

Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Phone _____ Date of last dental care _____

Please Complete Both Sides