Modern Smiles

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:________________________________ First Name:____________________________ Middle:___________

Sex:

Preferred Name:_____________________ ☐ Female ☐ Male Birthdate:_______________ Social Sec:___________________

Street address:____ P.O. Box______________________________

City:____________________________________ State:___________________ Zip Code:____________________

Home Phone:___________________________________ Cell Phone:_____________________________________

Options for Appointment Confirmation *(mark all that apply)* : ☐ Phone ☐ Text Message ☐ Email

Employer:______________________________________ Work Phone:_________________________________ Ext:_________

Email Address:____

Parents' or Guardian's Name *(if under the age of 18)*:____

How were you referred to our office?____

DENTAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Policy Holder's Name:____ Birthdate:__________________________

Relationship to Policy Holder:

Social Sec:_________________________ Employer:______________________________ ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of friend or relative:____ Relationship to patient:______________________

Home Phone:___________________________________ Cell Phone:_____________________________________

PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE

I authorize my insurance to pay Modern Smiles all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits. I understand Modern Smiles cannot render services on all assumption that any of the charges will be paid by an insurance company. **I understand that I am financially responsible for all charges paid by my insurance and my out-of-pocket charges. I understand that if I do not pay my bill, collection actions will be taken, and I will be responsible for paying any collection and attorney fees. There will be a $50.00 (per hour you are scheduled) charge for any missed appointments unless 24 hour notice is given prior to missing your appointments.**

Signature: ____ **Date:** __________________________________