Atlantic Smiles, LLC Patient Registration

Patient Information:

First Name: __________________ Last Name: ____________________Middle Initial: ___

Patient is: ☐ Policy Holder Preferred Name: __________________

☐ Responsible Party

Birth date: M: ________ D: _______ Y: _________

Social Security Number: ___________ / ________ / _____________

Address: __________________________________ Address 2: _______________________

City: ____________________________ State/Zip: ___________ /_____________

Home Phone: _____________________ Work Phone: ________________ Ext: ________

Cell Phone: ______________________ email: ______________________________

Sex: ☐ Male ☐ Female

Marital Status: ☐Married / ☐Single / ☐Divorced / ☐Separated / ☐Widowed

☐ I would like to receive correspondences via email

☐ I would like to receive correspondences via text

☐ Check here for both

Drivers License Number: __________________________________

Employment Status: ☐Full Time ☐Part Time ☐Retired

Student Status: ☐Full Time ☐Part Time

Preferred Pharmacy ______________________________

Preferred Hygienist ______________________________

Referred By: ______________________________

Emergency Contact (Name): ________________________ Phone: ___________________

Responsible Party (If someone other than patient)

First Name: __________________ Last Name: ____________________Middle Initial: ___

Address: __________________________________ Address 2: _______________________

City: ____________________________ State/Zip: ___________ / ______________

Home Phone: _____________________ Work Phone: ________________ Ext: ________

Cell Phone: ______________________ email: ______________________________

Birth date: M: ________ D: _______ Y: _________

Social Security Number: __________ / ________ / ____________

Drivers License Number: _________________________________

☐Responsible Party is also a Policy Holder for Patient

☐Responsible Party is also a Primary Insurance Policy Holder

☐Responsible Party is also a Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: ____________________________ ID#_________________________

Relationship to Insured: ☐Self / ☐Spouse/ ☐Child / ☐Other

Insured Social Security Number: ___________ / ______ / _____________

Insured Birth date: M: ________ D: _______ Y: _________

Employer: ______________________________

Address: _________________________ Address 2: ______________________

City, State, Zip: ______________________________________

Insurance Company: ____

Address: __________________________ Address 2: _____________________

City, State, Zip: ______________________________________

Secondary Insurance Information

Name of Insured: _____________________________ ID#________________________

Relationship to Insured: ☐Self / ☐Spouse/ ☐Child / ☐Other

Insured Social Security Number: ___________ / ______ / _____________

Insured Birth date: M: ________ D: _______ Y: _________

Employer: ______________________________

Address: _________________________ Address 2: ______________________

City, State, Zip: ______________________________________

Insurance Company: ____

Address: __________________________ Address 2: _____________________

City, State, Zip: ______________________________________

To the best of my knowledge, the questions on this form have been accurately answered.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

____ Date: ____________________