ALL ABOUT SMILE DENTAL GROUP

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

1

– IF THIS APPOINTMENT IS FOR YOU START HERE

Date			
Last name	First	M.I.	
Prefers to be called by			
Address			
City	State	ZIP	
Home Phone No.	Fax		
Cell	Email		
Birthdate	Age	☐ Male	☐ Female
☐ Married	☐ Single	☐ Divorced	☐ Widowed
Social Security No.			

– IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

Date			
Last name	First	M.I.	
Prefers to be called by			
Address			
City	State	ZIP	
Home Phone No.			
Birthdate	Age	☐ Male	☐ Female
School	Grade		
Social Security No.			

If your child's last name and/or address are not the same as yours, fill in the top box also

2 DENTAL INSURANCE

PRIMARY CARRIER	
Insurance Company	
Group No.	
Employer Name	
Insured's Name	
Date of Birth	
Relationship to Patient	
Insured's I.D. No.	
Insured's Social Security No.	

SECONDARY CARRIER	
Insurance Company	
Group No.	
Employer Name	
Insured's Name	
Date of Birth	
Relationship to Patient	
Insured's I.D. No.	
Insured's Social Security No.	

3 GETTING TO KNOW YOU

Is another member of your family or relative a patient at our office?		
Name:		
Relationship:		
You were reffered to us by		
Name:		
Person to contact for emergency		
Name:		
Cell number:		
Home number:		
Address:		
City:	State:	ZIP:

4 ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
Name:		
Relationship to Patient:		SS No.
Address:		
City:	State:	ZIP:
Phone No.		
YOU		
Name:		
Occupation:		
Employer's Name:		
Address:		City:
Phone No.		Fax
YOUR SPOUSE		
Name:		
Occupation:		
Employer's Name:		
Address:		City:
Phone No.		Fax

Signature: _____

Date: _____

Chino Office
12604 Central Avenue
Chino, CA 91710
(909) 591-1745

Encino Office
16133 Ventura Blvd, #1120
Encino, CA 91436
(818) 788-0651

Rancho Cucamonga Office
10630 Town Center Drive, Suite 131
Rancho Cucamonga, CA 91730
(909) 987-6643

allaboutsmiledentalgroup.com