THURMONT SMILES
Advanced Family Dentistry

PATIENT REGISTRATION

Date: ________________

First Name: ________________ M.I. ___ Last Name: ____________________ ☐ male ☐ female Date of Birth: ____________ *(Enter as MM/DD/YYYY)* Age: ____

Address: ____ City: ____________________ State: _____ Zip: __________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________ Social Security #: ____________ *(Do NOT include dashes or spaces)*

Email Address: _______________________________________ Emergency Contact: ___________________________________

Marital Status: ☐ Married ☐ Single Student: ☐ Full-time ☐ Part-time ☐ N/A Occupation: ___________________________

What would you prefer to be called? ____________________ Who may we thank for this referral? ___________________________

Have you seen us on: ☐ Facebook ☐ Twitter ☐ YouTube ☐ Google Reviews ☐ Television ☐ Local Magazine ☐ Newspaper

PRIMARY INSURANCE POLICY

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: __________________________________ Sub. ID#: __________________ Sub. DOB: __________________

Insurance Company: ____ Phone: __________________

Employer: _____________________________________ Group Name: ____________________ Group #: __________________

SECONDARY INSURANCE POLICY

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: __________________________________ Sub. ID#: __________________ Sub. DOB: __________________

Insurance Company: ____ Phone: __________________

Employer: _____________________________________ Group Name: ____________________ Group #: __________________

AUTHORIZATION

I attest that I understand and answered all the above questions honestly and completely. I authorize the release of information to insurance carriers and other health care professionals who are involved in my care. I assign my insurance benefits to Thurmont Smiles unless otherwise indicated.

Name of Parent/Guardian: ______________________________
(If patient is a minor)
Relationship to Patient: ______________________________

Patient/Guardian Signature Date: