PATIENT REGISTRATION

PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU - THANK YOU

PATIENT LAST NAME: _____ **FIRST:** _____ **INITIAL:** _____

How do you wish to be addressed? _____ DOB _____

(❑ Single ❑ Married ❑ Divorced ❑ Widowed) (❑ Male ❑ Female) Full time Student? ❑ Yes ❑ No School _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____ Social Security # _____

Employer _____ Occupation _____

How did you hear about our practice? Whom may we thank for your referral? _____

DENTAL INSURANCE INFORMATION

PRIMARY CARRIER

Insured's Name: _____

Date of Birth: _____

Social Security Number: _____

Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group Plan/Policy No: _____

DENTAL INSURANCE INFORMATION

SECONDARY CARRIER

Insured's Name: _____

Date of Birth: _____

Social Security Number: _____

Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group Plan/Policy No: _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Social Security # _____ Dental Insurance Co. _____ Group _____

NEAREST RELATIVE

Last Name _____ First _____ Initial _____

Address _____

City _____ State _____ Zip _____ E-Mail _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

AUTHORIZATION

I authorize Mark D. Evans, DDS and his associates to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my health care, advice and treatment to any professional provider I may be referred to.

I hereby authorize payment of insurance benefits directly to Mark D. Evans, DDS, otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full. By signing this statement, I agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I authorize Natural Smiles the office of Mark D. Evans to communicate with me via phone (voicemail may be left), email or text message.

I attest to the accuracy of the information on this page.

Signature _____ Date _____