Elite Smiles
Patient Registration

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City/State: _____ Zip: _____

Birth Date: _____ Age: _____ SSN: _____ Sex: Male ___ Female ____

Driver's License Number: _____ Marital Status: _____ Previous Dentist: _____

Phone number : _____

Email Address: _____

EMERGENCY CONTACT:

How did you hear about our office?

_____ Phone Number: _____

Relationship: _____

Dental Insurance Information (Policy Holder):

Subscriber's First Name: _____ Middle Initial: ___ Last Name: _____

Subscriber's Relationship To Patient: _____ Subscriber's DOB: _____

Subscriber's SSN: _____ Insurance Company: _____

Subscriber's Employer: _____ Group Number: _____

Responsibly Party (If someone other than Patient)

First Name: _____ Middle Initial: ___ Last Name: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ SSN: _____

Driver's License Number: _____

Regarding HIPAA:

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you information about our privacy practices. By signing below, you are acknowledging you have received a copy of our HIPPA privacy handout.

Signature: _____ Date: _____