

Columbia Smiles Family Dentistry PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION
In Order To Properly Complete Your Insurance Claims, We Must Have All Information Entered

DATE	EMAIL ADDRESS
_____	_____
NAME	_____
_____	_____
SPOUSE	_____
_____	_____
ADDRESS	_____
_____	_____
CITY	STATE ZIP
_____	_____
HOME PHONE	CELL PHONE
_____	_____
BIRTHDATE AGE	MALE FEMALE
_____	_____
MARRIED SINGLE DIVORCED WIDOWED	_____
_____	_____
SOCIAL SECURITY NO.	_____
_____	_____
_____	_____

DATE		

NAME		

ADDRESS		

CITY	STATE	ZIP
_____	_____	_____
HOME PHONE NO.		

BIRTHDATE AGE	MALE FEMALE	
_____	_____	
SOCIAL SECURITY NO.		



DENTAL INSURANCE	
PRIMARY CARRIER	

EMPLOYER NAME	

INSURANCE COMPANY	

GROUP NO.	

EMPLOYEE	

DATE OF BIRTH EFFECTIVE DATE	
_____	_____
EMPLOYEE NO.	

EMPLOYEE SOCIAL SECURITY NO.	

CLAIMS OFFICE MAILING ADDRESS	

CLAIMS OFFICE TOLL-FREE PHONE #	

SECONDARY CARRIER	

EMPLOYER NAME	

INSURANCE COMPANY	

GROUP NO.	

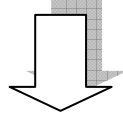
EMPLOYEE	

DATE OF BIRTH EFFECTIVE DATE	
_____	_____
EMPLOYEE NO.	

EMPLOYEE SOCIAL SECURITY NO.	

CLAIMS MAILING ADDRESS	

CLAIMS OFFICE TOLL-FREE NUMBER	



GETTING TO KNOW YOU		
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? _____		
NAME		

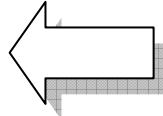
REFERRED BY		

EMERGENCY CONTACT		

PHONE NUMBER		

ADDRESS		

CITY	STATE	ZIP
_____	_____	_____
_____	_____	_____



ACCOUNT INFORMATION		
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		

RELATIONSHIP TO PATIENT		

ADDRESS		

CITY	STATE	ZIP
_____	_____	_____
PHONE NUMBER		

YOU		

NAME		

OCCUPATION	EMPLOYER	
_____	_____	
BUSINESS ADDRESS		

BUSINESS PHONE NO.		

YOUR SPOUSE		

NAME		

OCCUPATION	EMPLOYER	
_____	_____	
BUSINESS ADDRESS		

BUSINESS PHONE NO.	EXTENSION	
_____	_____	
_____	_____	