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

ADULT-START HERE

DATE **EMAIL ADDRESS**

NAME

SPOUSE

ADDRESS

CITY **STATE** **ZIP**

HOME PHONE **CELL PHONE**

BIRTHDATE **AGE** **MALE** **FEMALE**

MARRIED **SINGLE** **DIVORCED** **WIDOWED**

SOCIAL SECURITY NO.

CHILD-START HERE

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

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**

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**