middleton smiles
Family Dentistry

Patient Registration Form

Patient Information

Patient Name (First, MI, Last)_____ Preferred:_____

Date of Birth:_____ Sex: M F Married Single Divorced Widowed

Address_____ City_____ State _____ Zip_____

Preferred Phone#: _____ Is this a mobile #? Y N SSN#:_____

Employer:_____ Email Address:_____

Spouse Name:_____ Phone #_____ DOB:_____

Spouse Employer:_____ Spouse SSN#: _____

We routinely confirm appointments and communicate by text messaging to cell phones. (Standard text rates apply.) If you wish to *opt out* of communication via text message, please indicate here: ☐

Responsible Party Self ☐

First Name: _____MI:_____ Last Name: _____ Sex: M F

Address_____City_____State _____Zip_____

Date of Birth: _____ Phone #:_____ SSN#:_____

Responsible Party Signature: _____ Date: _____

Preferred Pharmacy

Preferred Pharmacy Name: _____ Phone Number: _____

Street Location and City: _____

Primary Dental Insurance: Is subscriber the same as patient? Yes No

Subscriber Information:

First Name: _____MI:_____ Last Name: _____ Sex: M F

Insurance Company: _____Ins Phone Number: _____

Address: _____ State: _____ Zip:_____

Subscriber ID/Policy Number: _____ Date of Birth:_____

Patient Relationship to Subscriber: _____ Subscriber SSN#: _____

(SSN# is often used in the use of Insurance billing and benefits, it will ONLY be used for those purposed)

Secondary Dental Insurance:

Subscriber Information:

First Name: _____MI:_____ Last Name: _____ Sex: M F

Insurance Company: _____Ins Phone Number: _____

Address: _____ State: _____ Zip:_____

Subscriber ID/Policy Number: _____ Date of Birth:_____

Patient Relationship to Subscriber: _____ Subscriber SSN#: _____

I verify that the information I have provided is true and accurate and will update this office as changes occur. I have read, understand, and agree to follow the Financial Policy stated above.

Signature: _____ Date: _____