CHESAPEAKE SMILES PATIENT REGISTRATION

Patient Information:

First Name: ___________________________Last Name: _______________________ Middle Initial:____

Preferred Name: _____________________________________

Address: ____________________________________ City, State, Zip: ____________________________

Home Phone: ________________Work Phone: __________________Cell Phone: __________________

Sex: □ Female □ Male Marital Status: □ Married □ Single □ Divorced □ Separated □Widowed

Birth Date: ________________ Social Security #: _______________________

E-mail: ____

□ I would like to receive email/text correspondences

Responsible Party: (if someone other than the patient)

First Name: _______________________Last Name: ________________________Middle Initial: ______

Address: _____________________________________City, State, Zip: ____________________________

Home Phone: _________________Work Phone: _________________Cell Phone: __________________

Sex: □ Female □Male Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed

Birth Date: ________________ Social Security #: _______________________

□ Responsible Party is Policy Holder for Patient □ Primary Policy Holder □ Secondary Policy Holder

Primary Insurance Information:

Name of Policy Holder: ___________________________Relationship to Insured: □Self □Spouse □Child

Policy Holder Social Security #: ___________________ Policy Holder Birth Date: _________________

Employer: _______________________________ Insurance Company: ____________________________

Secondary Insurance Information:

Name of Policy Holder: ____________________________Relationship to Insured: □Self □Spouse □Child

Policy Holder Social Security #: ____________________ Policy Holder Birth Date: ________________

Employer: _______________________________ Insurance Company: ____________________________

Have you ever been treated at Family Dentistry
(located at 677 Old Mill Road Millersville, MD 21108) before?
□Yes □No

____ ______________________

Signature of Patient, Parent or Guardian Date