REGISTRATION FORM

SUMMIT SMILE INNOVATIONS

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181 W Wilkes Medical Center Rd
Ferguson, NC 28624
336.973.5060

Section 1 Patient Information Date _____

Name: _____ Middle Initial: _____ Preferred Name: _____

Address: _____ City:_____ State: _____ Zip:_____

Home Phone: (_____)_____ Work Phone: (_____) _____ Cell Phone: (_____)_____

Best time to contact me is: _____ ☐ AM ☐ PM on my ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Date of Birth: _____ Social Security Number: _____ ☐ You can contact me at work

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School: _____ City/State: _____ ☐ FT ☐ PT

Name of spouse or parent: _____ Employer: _____Work Phone: (_____)_____

Are you retired? ☐ Yes ☐ No If you are retired, how were you formerly employed? _____

Person to contact in case of emergency: _____ **Phone**: (_____)_____

Whom may we thank for referring you? _____

Email Address _____ Would you like to receive our e-notifications? ☐ YES ☐ NO

Section 2 Responsible Party

Relationship to Patient: ☐ Self *(Skip to Section 3)* ☐ Spouse ☐ Parent ☐ Other *(explain)* _____

Name: _____

Address: _____

City: _____ State:_____ Zip:_____ Phone: : (_____)_____

Employer:_____ Work Phone: (_____)_____ SSN#:_____

Section 3 Dental Insurance Information

Name of Insured: _____ DOB: _____ Relationship to Patient: _____

SSN#:_____ Name of Employer: _____ Work Phone: (_____)_____

Address of Employer: _____ City:_____ State: _____ Zip:_____

Insurance Company: _____ Grp #: _____ ID#: _____

Ins Co Address: _____ Ins Co Phone: (_____)_____

Signature: