proudsmiles
A Health-Centered Dental Practice

REGISTRATION FORM

Name: _____
Last First Initial

How would you like to be addressed? _____

Address: _____ Apt# _____
City: _____ State: _____ Zip Code: _____

Home Number: _____
Mobile Number: _____
Work Number: _____
Email: _____

Patient SSN #: _____
Driver's License #: _____
Person Responsible: _____

Marital Status:
☐ Single ☐ Married ☐ Separated ☐ Divorced

Other family members that are Proud Smiles patients:
_____

Whom may we thank for this referral:
_____

Contact Preferences:

I consent to be contacted as follows:

	TEXT	PHONE	EMAIL	MAIL
Appointments	☐	☐	☐	☐
Special Offers	☐	☐	☐	☐
Greeting	☐	☐	☐	☐
Benefits & Payment Information	☐	☐	☐	☐
Newsletters / Announcements	☐	☐	☐	☐
Surveys / Feedback Request	☐	☐	☐	☐

I attest to the accuracy of the information on this document

_____
Patient or Guardian's Signature

_____
Date

Date of Birth: _____

Gender: ☐ Male ☐ Female
Gender Pronoun: _____

Primary Dental Insurance

Insurance Company: _____
Insurance Company Phone #: _____
Subscriber Name: _____
Subscriber Date of Birth: _____
Subscriber SSN #: _____
Member ID #: _____
Group #: _____
Group/Employer Name: _____

Secondary Dental Insurance

Insurance Company: _____
Insurance Company Phone #: _____
Subscriber Name: _____
Subscriber Date of Birth: _____
Subscriber SSN #: _____
Member ID #: _____
Group #: _____
Group/Employer Name: _____