Broadway Smiles
EXCEPTIONAL DENTISTRY

PATIENT REGISTRATION

PATIENT INFORMATION

Today's Date _____

Patient's Name _____
Last

_____
First Middle Initial

Sex ☐ M ☐ F Birthdate _____ Age _____

Social Security # _____ Marital Status _____

Street Address _____

City _____ State _____ Zip _____

Home# _____ Work# _____

Cell# _____

Email _____

HOW DID YOU HEAR ABOUT US? _____

WHO MAY WE THANK FOR REFERRING YOU?

_____

If patient is a minor (under 18), give parent or guardian name:

_____

If you are 18 and older, you are responsible for any deductibles and co-insurance amounts at the time of service, unless previous arrangements have been made with the Office Manager.

ACCOUNT INFORMATION

Responsible Party Self _____ Parent _____ Spouse _____

Last Name _____

First Name _____

Address _____

City _____ State _____ Zip _____

Home# _____ Work# _____

Cell# _____

SS# _____ Birthdate _____

Email _____

DENTAL INSURANCE

Insured's Name _____

Insurance Co. _____
Insurance Address _____

Insured's Employer _____

SS# _____ Birthdate _____

Group# _____

Secondary Insurance will need to be submitted by the patient once the Explanation of Benefits is received from your primary insurance.

EMERGENCY CONTACT

Whom should we contact? _____

Relation _____

Home # (_____) _____

Work#: (_____) _____

Cell Phone# (_____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone # (_____) _____

CONSENT

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. I am responsible to pay my estimated coinsurance and deductible at the time of service. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

Patient Signature (Parent if child) _____ Date: _____ Dentist Signature: _____