Serenity Smiles

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Master of the Academy of General Dentistry
Master of the College of Sedation in Dentistry of the American Dental Society of Anesthesiology
Diplomate of the Dental Organization for Conscious Sedation
Diplomate of the American Board of Oral Implantology/Implant Dentistry

Implants, General, Cosmetic, IV Sedation

Serenity Smiles Patient Registration

First Name _____ Last Name _____ Middle Initial _____

Are you a: ❑ Policy Holder ❑ Responsible Party Preferred name _____

Responsible party (if someone other than the patient) _____

Patient Information

Address _____

City, State _____ Zip _____

Home Phone ( ) _____ Work Phone ( ) _____ Ext _____ Cellular ( ) _____

Birth Date / / Soc. Sec - - Drivers License ***State:*** ***No:***

Sex: ❑ Male ❑ Female **Marital Status** ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

E-mail _____ @ _____

Employment Status ❑ Full Time ❑ Part Time ❑ Retired

Student Status ❑ Full Time ❑ Part Time ❑

Who can we thank for referring you to our Serenity Smiles? _____

What are your preferred pharmacies? _____ _____

Who is your Emergency Contact person? _____ Emergency Contact Phone # ( ) _____

Are you available on short notice to come to our office for treatment? ❑ Yes ❑ No

If you are available on short notice, what days of the week and what times? _____

Responsible Party (if someone other than the patient)

❑ **Responsible party is also a policy holder for patient** ❑ Primary Insurance policy holder ❑ Secondary Insurance Policy holder

First Name _____ Last Name _____ Middle Initial _____

Address _____

City, State _____ Zip _____

Home Phone ( ) _____ Work Phone ( ) _____ Ext _____ Cellular ( ) _____

Birth Date / / Soc. Sec - - Drivers License ***State:*** ***No:***

Dental Insurance Information (Primary Insurance)

Name of insured _____ Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Social Security # - - Insured Birth Date / /

Employer Information

Employer _____

ID number _____

Address _____

City, State,Zip _____

Primary Insurance Information

Insurance Co _____

ID number _____

Address _____

City, State,Zip _____

Dental Insurance Information (Secondary Insurance)

Name of insured _____ Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Social Security # - - Insured Birth Date / /

Employer Information

Employer _____

ID number _____

Address _____

City, State,Zip _____

Secondary Insurance Information

Insurance Co _____

ID number _____

Address _____

City, State,Zip _____