2233 W. Baseline Rd Suite #104 Tempe, AZ 85283 (602) 438-9245

Dental Registration and Treatment

Date____________________

Patient Information

Patient Name ________________________________
Preferred Name _________Date of Birth___________
Social Security #______________________________
Address__________________________Apt#________
City ____________________Zip__________________
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Employer/School______________________________

☐ Full Time ☐ Part Time ☐ Male ☐ Female

What is the best way to contact you?

☐ Email Me ☐ Call Me ☐ Text Me

Home ________________ Cell ___________________

Work _____________Email______________________

How did you hear about South Mountain Family Dental?

☐ Personal Referral___________________________

☐ Mailing ☐ Yelp ☐ Mouthguard Promo

☐ Google ☐ Building Sign ☐ Insurance

☐ Website ☐ Other____________________

Primary Dental Insurance

Subscriber Name _____________________________

Relationship to patient_________________________

Subscriber's Date of Birth______________________

Subscriber's SS/ID#___________________________

Address (if different from patient) _____________________

Subscriber's Employer__________________________

Insurance Company ____________________________

Group #

Secondary Dental Insurance

Subscriber Name _____________________________

Relationship to patient_________________________

Subscriber's Date of Birth______________________

Subscriber's SS/ID#___________________________

Address (if different from patient) _____________________

____

Subscriber's Employer__________________________

Insurance Company ____________________________

Group #_______________________________________

Assignment and Release

If you have Dental Insurance, please read below and sign.

I certify that I, and/or my dependant(s) have insurance coverage with ________________________________and assign
Name of Insurance Company
directly to South Mountain Family Dental and its associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

South Mountain Family Dental and its associates may use my health care information and may disclose such information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

*All family accounts will be linked together for financial/insurance purposes unless otherwise requested.

____
Signature of patient or personal representative

____
Print name of patient or personal representative

___________________ ______________________
Date Relationship to Patient

Emergency Contact Information

Name: ______________________ Cellular________________________Relationship__________________

Name: ______________________ Cellular________________________Relationship__________________