

Summit Dental Patient Registration

Patient Information Please Print

First name: _____		Last name: _____		Middle Initial: _____	
Address: _____			Apt. Number : _____		
City: _____		State: _____		Zip: _____	
Home phone :(_____) _____ - _____		Cell: (_____) _____ - _____		Text Messaging: <input type="checkbox"/> Opt In <input type="checkbox"/> Opt Out (See Below**)	
Email address: _____			Email: <input type="checkbox"/> Opt In <input type="checkbox"/> Opt Out (See Below**)		
Birth Date: _____		Age: _____		Social Security #: _____	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed					
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired					
Name of Employer: _____		City, State: _____		Work phone: (_____) _____ - _____	
Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		Name of School _____		City, State: _____	
Preferred Pharmacy: _____					
Physicians Name: _____			Phone: _____		
Main Dental concern: _____					
Do you use a pre-medication prior to dental treatment (Antibiotic)? _____					
How did you find our office? (Referral Source) _____					
EMERGENCY CONTACT _____				Phone:(_____) _____ - _____	

**We provide our patients the option to participate in our online patient communication system. Some of the features include the ability to:

- Request Appointments Online
- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Submit Patient Satisfaction Surveys
- Refer Your Friends Online

You may opt-out of communications at any time by clicking the unsubscribe link in the footer of each email or by replying to a text message with 'STOP'.

Responsible Party (if someone other than patient)

First name: _____		Last name: _____		Middle Initial: _____	
Address: _____			Apt. Number : _____		
City: _____		State: _____		Zip: _____	
Home phone :(_____) _____ - _____		Work phone: (_____) _____ - _____		Cell: (_____) _____ - _____	
Birth Date: _____		Soc. Sec: _____		Relationship to Patient: _____	
<input type="checkbox"/> Responsible party is also the Policy Holder for Patient <input type="checkbox"/> Primary Insurance Holder <input type="checkbox"/> Secondary Insurance Holder					

Insurance Information (please provide insurance card)

Name of Policy Holder: _____		Policy Holder Birth Date: _____			
Relationship of patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Policy Holder SSN-or-ID #: _____			
Address (if different than patient's): _____					
City: _____		State: _____		Zip: _____	
Name of Policy Holder's Employer: _____		City, State: _____			
Name of Insurance Company: _____		Address: _____			
City: _____		State: _____		Zip: _____	