smileLOGIC ORTHODONTICS

New Patient Registration Form

Patient Information

Patient Name ______________________ Date of Birth ______________________ Male Female

Home Address ______________________

Email ______________________ Phone ______________________

Emergency Contact Name ______________________ Emergency Contact Phone ______________________

Dentist Name ______________________ Date of Last Visit ______________________

Whom may we thank for referring you to our office? ______________________

Responsible Party Information

Name ______________________ Relationship to Patient ______________________

Billing Address ______________________

Billing Email ______________________ Billing Phone ______________________

Dental Insurance Information

Primary Insurance ______________________

Group Number ______________________

ID Number ______________________

Policy Holder Name ______________________

Date of Birth ______________________

Social Security Number ______________________

Secondary Insurance ______________________

Group Number ______________________

ID Number ______________________

Policy Holder Name ______________________

Date of Birth ______________________

Social Security Number ______________________

I authorize the release to my insurance company or companies any information, including the diagnostic records and diagnosis of any treatment required, to comply with applicable law and facilitate the billing and reimbursement for the treatment provided. I authorize payment be made to Smile Logic Orthodontics by my insurance carrier.

______________________ ______________________

Signature of Patient/Parent/Guardian Date

HIPAA Acknowledgement

I have received or been offered a copy of the “Notice of Privacy Practices” to read, and any questions I had were answered to my satisfaction.

______________________ ______________________

Signature of Patient/Parent/Guardian Date