Sevierville Smiles
The Dental Excellence

REGISTRATION FORM

PATIENT INFORMATION

Date_____

Name*:_____ Preferred Name: _____
(Last) (First) (MI)

Date of Birth*:_____ Social Security Number*:_____ Gender: ☐ M ☐ F
(MM/DD/YYYY)

Address*:_____City:_____State:_____Zip:_____

Email Address*:_____ Home Phone*: (_____)_____

Cell Phone*:(_____)_____ Cell Phone Can Receive Text Messages*: ☐ Yes ☐ No

Employer:_____ Work Phone: (___ _)_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School:_____ City/State:_____ ☐ FT ☐ PT

Spouse or Parent's Name:_____ Employer:_____ Work Phone:(_____)_____

Whom may we thank for referring you? _____

Person to contact in case of emergency*:_____ Phone*: (_____)_____

INSURANCE INFORMATION

Name of Insured:_____ DOB:_____ Relationship to Patient: _____
(Last) (First) (MI) (MM/DD/YYYY)

SSN#:_____ Name of Employer:_____ Work Phone: (_____)_____

Address of Employer:_____City:_____State:_____Zip: _____

Insurance Company:_____ Group #:_____ ID #:_____

Ins Co. Address:_____ Ins Co. Phone: (_____)_____
(Please present insurance card to the receptionist)

ADDITIONAL INSURANCE

Name of Insured:_____ DOB:_____ Relationship to Patient: _____
(Last) (First) (MI) (MM/DD/YYYY)

SSN#:_____ Name of Employer:_____ Work Phone: (_____)_____

Address of Employer:_____City:_____State:_____Zip: _____

Insurance Company:_____ Group #:_____ ID #:_____

Ins Co. Address:_____ Ins Co. Phone: (_____)_____
(Please present insurance card to the receptionist)

*Required Information