YEARLY UPDATE REGISTRATION FORM

DATE:_____/_____/_____ **HOME PHONE:** (_____)_____-_____ **CELL PHONE:** (_____)_____-_____

LAST NAME:_____ **FIRST NAME:**_____

ADDRESS:_____**APT #**_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

SEX: M ☐ **F** ☐ **AGE:**_____ **BIRTHDAY:**_____/_____/_____ **SSN:**_____-_____-_____

IN CASE OF EMERGENCY WHO SHOULD WE CONTACT:_____ PHONE: (_____)_____-_____

PATIENT EMPLOYER/SCHOOL:_____ ___ **OCCUPATION:**_____

SINGLE ☐ **MARRIED** ☐ **WIDOWED** ☐ **SEPARATED** ☐ **DIVORCED** ☐ **MINOR** ☐ **PARTNERED FOR** _____**YEARS**

Referred By:_____

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT LAST NAME:_____**FIRST NAME:**_____

RELATION TO PATIENT:_____ **BIRTHDAY:**_____/_____/_____

ADDRESS IF DIFFERENT FROM PATIENT:_____**APT #**_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

IS THE PATIENT: SUBSCRIBER ☐ **SPOUSE** ☐ **DEPENDENT** ☐

INSURANCE NAME:_____**INSURANCE PHONE: (**_____**)**_____-_____

SUBSCRIBER ID OR SSN#:_____ **GROUP #**_____

I _____ authorize my insurance benefits to be paid to **Smile America Dental Center**. I authorize **Smile America Dental Center** to release any information for the claim to be paid by my insurance. I also authorize that any records can be used by my dentist if he/she determines the need. I understand that I am financially responsible for any unpaid services by my insurance.

Effective July 1st, 2015, we will be charging a fee of **$25.00** for any appointment that is missed without calling to cancel or reschedule within 24 hours of the scheduled appointment time.

I certify that I have read or had read to me the contents of this form.