Patient Registration

Patient Information

First Name: Last Name:

Address: City: State: Zip:

Social Security: Home Phone: Work Phone w/Ext

Cellular: Pager: E-Mail

Sex: ☐ Male ☐ Female Date of Birth / / Age: ☐ Please send correspondences via e-mail

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Mother's Information ☐ Select box if you are the one who brought in the child today

First Name: Last Name:

Address: City: State: Zip:

Social Security: Home Phone: Work Phone w/Ext

Cellular: Pager: E-Mail

Sex: ☐ Male ☐ Female Date of Birth / / Age: ☐ Please send correspondences via e-mail

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Father's Information ☐ Select box if you are the one who brought in the child today

First Name: Last Name:

Address: City: State: Zip:

Social Security: Home Phone: Work Phone w/Ext

Cellular: Pager: E-Mail

Sex: ☐ Male ☐ Female Date of Birth / / Age: ☐ Please send correspondences via e-mail

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Responsible Party ☐ Select box if you are the one who brought in the child today

First Name: Last Name:

Address: City: State: Zip:

Social Security: Home Phone: Work Phone w/Ext

Cellular: Pager: E-Mail

Sex: ☐ Male ☐ Female Date of Birth / / Age: ☐ Please send correspondences via e-mail

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Insurance Information

Name of Insured: Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Date of Birth / / Social Security:

Employer: Employer Telephone:

Employer Address: City State Zip:

Insurance Company: Insurance Phone:

Policy Number: Group Number:

Insurance Information

A certify that I (or my dependent) have insurance coverage as indicated and adding directly to this office all insurance benefits 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 doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Date / /

Relationship to Minor (if applicable)

Staff Int.

CuteSmiles4Kids 823 Bandera Road San Antonio, TX 78228 **PHONE** 210-435-3333 **FAX** 210-435-3334 **WEB** www.cutesmiles4kids.com