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: □ Opt In □ Opt Out (See Below**)
Email address:____Email: □ Opt In □ Opt Out (See Below**)
Birth Date: ___________________________________ Age: _______ Social Security #: ___________________________
Sex: □ Male □ Female Marital Status: □ Married □Single □ Divorced □ Separated □ Widowed
Employment Status: □ Full Time □ Part Time □ Retired
Name of Employer:____________________________ City, State: _________________________ Work phone: (_____) _____-________
Student Status: □ Full Time □ 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'. Standard Text Messaging rates apply.

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:_____________________
□ Responsible party is also the Policy Holder for Patient □ Primary Insurance Holder □ Secondary Insurance Holder

Insurance Information (please provide insurance card)

Name of Policy Holder:____ **Policy Holder Birth Date**:______________________
Relationship of patient: □ Self □ Spouse □ Child □ 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: ________________________