1801 NW Market St.
Suite 312
Seattle, WA 98107
206.784.6310

PATIENT REGISTRATION

DATE:______/_____/______ PREFERRED NAME:______________________________

NAME	SEX ☐M ☐F	☐ CHILD ☐ MARRIED	☐ SINGLE ☐ OTHER	BIRTH DATE
SPOUSE'S NAME/PARENT'S NAME (IF MINOR)	YOUR SOC. SEC. #			HOME PHONE
ADDRESS	CITY		ZIP	CELL PHONE
WHO REFERRED YOU?	EMPLOYER	OCCUPATION		WORK PHONE
YOUR EMAIL ADDRESS	EMERGENCY CONTACT (OTHER THAN SPOUSE)			

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE	GROUP#/EMPLOYER	NAME OF SUBSCRIBER (IF NOT SELF)	BIRTH DATE	INS. ID # OR SOC. SEC. #
SECONDARY DENTAL INSURANCE	GROUP#/EMPLOYER	NAME OF SUBSCRIBER (IF NOT SELF)	BIRTH DATE	INS. ID # OR SOC. SEC. #

MY PRIMARY PREFERENCE FOR COMMUNICATION:

TEXT____

EMAIL____

PHONE____

☐ **I have read Smile Ballard's financial policy.**_____*(initials)*

I am financially responsible for my own account. I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. If insurance coverage exists, I authorize payment to go directly to my dentist.

SIGNATURE____ DATE_________________________