CAROLINA
SMILE DESIGN

SUBMIT FORM

PATIENT REGISTRATION

Last Name: _____ First Name: _____ Middle Initial: _____

Patient is: Policy Holder ☐ Responsible Party ☐ Preferred Name: _____

Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Sex: Male ☐ Female ☐ Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

Birthdate: _____ Social Security Number: _____-_____-_____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Birthdate: _____/_____/_____ Social Security Number: _____-_____-_____

How did you hear about Carolina Smile Design?

- ○ Post Card
- ○ Web Search
- ○ Friend/Family
- ○ Insurance Company
- ○ Other_____

DENTAL INSURANCE INFORMATION

Name of insured: _____ Relationship to Patient: _____

Insured Date of Birth_____/_____/_____ Employer: _____

Name of Insurance Company: _____

Insured ID Number: _____ Group Number: _____