Patient registration

First Name

Last Name

Preferred Name

Middle Initial

Address

City

State

Zip

Primary Phone

Secondary Phone

Email

Drivers License

Birth Date

Age

Social Security Number

Preferred Dentist

Preferred Hygienist

Preferred Pharmacy

Additional Information/Comments

Insured/responsible party (if different from patient)

First Name

Last Name

Preferred Name

Middle Initial

Address

City

State

Zip

Primary Phone

Secondary Phone

Email

Drivers License

Birth Date

Age

Social Security Number

Bright Smiles of Coral Springs

BrightSmilesofCoralSprings.com

Patient ID

Chart ID

Medicaid ID

Employer ID

Member ID

Carrier ID

Patient is:

- ☐ Primary policy holder
- ☐ Secondary policy holder
- ☐ Responsible party

Responsible Party is:

- ☐ Primary policy holder
- ☐ Secondary policy holder

Primary insurance information

Employer

Insurance Company

Employer Address

Insurance Company Address

City, State, Zip

City, State, Zip

Employer Phone

Insurance Company Phone

Benefits

Deductible

Secondary insurance information

Employer

Insurance Company

Employer Address

Insurance Company Address

City, State, Zip

City, State, Zip

Employer Phone

Insurance Company Phone

Benefits

Deductible

Relationship to Insured:

- ☐ Self
- ☐ Spouse
- ☐ Child
- ☐ Other_____

Marital Status:

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Sex:

- ☐ Male
- ☐ Female

Employment Status:

- ☐ Full Time
- ☐ Part Time
- ☐ Retired

Student Status:

- ☐ Full Time
- ☐ Part Time