

Masterpiece Smiles, P.C.

Adult Patient Registration

The following information is for our records only and will be considered confidential.

Name _____ Preferred Name _____
Last First Middle Initial

Address _____ City _____ State _____ Zip _____

Birthdate _____

Home Phone _____ Cell Phone _____

E-Mail Address _____

How may we best contact you?(Select all that apply) Home Cell Work
E-Mail Text Message

Are any immediate family members current patients of record? Yes _____ No _____

If so, Name _____ Relationship to patient _____

Person Responsible for Account _____ Phone _____

Address _____ City _____ State _____ Zip _____

Who may we contact in case of emergency (other than spouse)? _____

Relationship to Patient _____ Phone _____

Present Employer _____ Phone _____ Ext _____

Can you be contacted at work? Yes _____ No _____

If Married, Spouses Name _____

Spouses Employer _____ Phone _____ Ext _____

Spare Time Activities, Special Interests, or Hobbies _____

Who may we thank for referring you to this office? _____

I will be paying by: Cash _____ Check _____ Credit Card _____ Care Credit _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have reviewed all of the above information and have completed the above questions. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or changes of the above information.

Signature _____ Date _____