Natural Smiles Dental Care

Adult Registration
3434 Lexington Ave N Suite 700 Shoreview, MN 55126
contact@naturalsmilesdental.com

*Date:*_____

Patient name:_____
*Nickname preferred:*_____
*Birthdate:*_____ *Male __ Female__*
*Home address:*_____
_____
*Phone:*_____
*Cell #:*_____*Work #:*_____
*Email:*_____

*Employer:*_____
*Address:*_____

*How did you hear about us?*_____

*Previous DDS:*_____
Person responsible for Account:

_____

*Spouse name:*_____
*Cell #:*_____*Wk #:*_____
*Birthdate:*_____

Dental coverage? Yes__ No__
*Insurance Co name:*_____
*Address:*_____
_____

Group # _____
*Insured's name:*_____
*Insured's birthdate:*_____
*Insured's ID #:*_____
*Insured's Employer:*_____

Any 2nd Insurance coverage? Yes__ No ___
*Insurance company:*_____
*Insured's name:*_____
*Insured's birthdate:*_____
*Insured's ID #:*_____
*Insured's employer:*_____

Payment is due in full at time of treatment. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles at each appointment that insurance does not cover. I hereby authorize payment directly to Natural Smiles Dental Care otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination, to my insurance company.

Signature *Date*