BrightSmiles

BRETT CLIFTON, DDS
PATIENT REGISTRATION

First Name:_____Last Name:_____Middle Initial_____

Preferred Name:_____

Patient is: **Responsible Party** **Policy Holder**

Patient Information:

Address:_____Address 2:_____

City, State, Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Can we text you for appointment reminders? YES NO

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

Birth Date:_____Social Security #:_____

E-mail:_____

Who may we thank for referring you to us?_____

Employment Status: **Full time Part time Self Employed Retired Unemployed**

Preferred Pharmacy:_____

Name of Employer:_____

Responsible party: (If someone other than the patient)

First Name:_____Last Name:_____Middle Initial_____

Address:_____Address 2:_____

City, State, Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Birth Date:_____Social Security #:_____

Responsible Party is: **Policy Holder for Patient** **Primary Policy Holder** **Secondary Policy Holder**

Primary Insurance Information:

Name of Insured:_____Relationship to Insured: **Self Spouse Child Other**

Insured Social Security #:_____Insured birth date:_____

Employer:_____Insurance Company:_____

Secondary Insurance Information:

Name of Insured:_____Relationship to Insured: **Self Spouse Child Other**

Insured Social Security #:_____Insured birth date:_____

Employer:_____Insurance Company:_____

_____

Patient Signature **Responsible Party** **Printed Name** **Date**