PATIENT REGISTRATION FORM

Welcome to GDC Smiles! To assist us in serving you, please complete the following confidential form. The information provided is important to properly registrar you as patient of our practice.

Today's Date _____/ _____/ _____

Patient's Name (complete) _____

Preferred Name: _____ **Gender: M**____ **F**____

Birth Date: Month: _____ Day: _____ Year: _____

Cell Phone #: _____ Home Phone #:_____

Email: _____

Street Address:_____ City_____ State _____ Zip_____

❑ Unmarried

❑ Married

Spouse's Name _____ Spouse's Phone #: _____

Emergency Contact _____ Relationship_____ Phone#_____

How did you find about us? _____

Name of the person who referred you to us: _____

We ask for the name of the referral source because we want to express our gratitude for his/her trust. Our office is committed to give all our patients the best customer service they can get. If for any reason you think we should improve in some areas please email to customerservice@gallodental.com with your concerns.

BILLING, CREDIT, AND INSURANCE INFORMATION:

❑ NO insurance

❑ YES insurance - Insurance Company Name: _____

Please provide copy of your insurance card to our Insurance Specialist who will gladly assist you in collecting the necessary information.

Social Security #:_____ State License or ID #:_____
(Please provide copy of your ID to our front desk personnel)

Occupation:_____ Employer:_____

What days of the week do you prefer your dental appointments to be scheduled?: _____

Do you prefer communications on a form of (**check all that apply**):

***Please note that we will use your mailing address to send you statements of Unpaid balances and other necessary written communications.**

____ Phone Calls
____ Texts
____ Emails
____ Mail

Patient's Signature/Guardian: _____