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PATIENT REGISTRATION AND HISTORY

Date _____ Cell Phone _____ Home Phone _____

Name _____ Soc.Sec.# _____
Last Name First Name

Address _____

City _____ State _____ Zip _____

Sex M ___ F ___ Age ___ Birthdate _____ Single ___ Married ___ Widowed ___ Separated ___ Divorced ___

Patient Employed by _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should we notify? _____

Primary Insurance

Person Responsible for account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc.Sec.# _____

Address(if different from the patient) _____ Phone# _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____ Business Phone _____

Business Address _____ Insurance Company _____ Group # _____

Name of other Dependents covered under this plan _____

Additional Information

Is patient covered by an additional insurance? Yes ___ No ___

Subscriber Name _____ Relation to patient _____ Birthdate _____

Address (if different from patient) _____ Phone# _____

City _____ State _____ Zip _____ Business Phone _____

Subscriber Employed by _____ Soc.Sec.#of member _____

Name of other dependents covered under this plan _____

Assignment and Release

I, the undersigned, certify that I (or my dependents) have insurance coverage with _____ and assign directly to Perfect Smiles Orthodontics, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I further authorize Perfect Smiles Orthodontics, PC to share information about my health with other Medical Professionals and laboratories.

Responsible Party Signature

Relationship

Date