

Patient Registration

Patient Information

First Name	Last Name	Middle Name
Date of Birth	Residential Address	City
State		
☐ Alabama	☐ Alaska	☐ Arizona
☐ Arkansas	☐ California	☐ Colorado
☐ Connecticut	☐ Delaware	☐ Florida
☐ Georgia	☐ Hawaii	☐ Idaho
☐ Illinois	☐ Indiana	☐ Iowa
☐ Kansas	☐ Kentucky	☐ Louisiana
☐ Maine	☐ Maryland	☐ Massachusetts
☐ Michigan	☐ Minnesota	☐ Mississippi
☐ Missouri	☐ Montana	☐ Nebraska
☐ Nevada	☐ New Hampshire	☐ New Jersey
☐ New Mexico	☐ New York	☐ North Carolina
☐ North Dakota	☐ Ohio	☐ Oklahoma
☐ Oregon	☐ Pennsylvania	☐ Rhode Island
☐ South Carolina	☐ South Dakota	☐ Tennessee
☐ Texas	☐ Utah	☐ Vermont
☐ Virginia	☐ Washington	☐ West Virginia
☐ Wisconsin	☐ Wyoming	☐ Puerto Rico
☐ District of Columbia	☐ US Virgin Islands	
Zip		

Gender		
☐ Male	☐ Female	☐ Other

How did you hear about us?

Marital Status		
☐ Single	☐ Married	☐ Divorced
☐ Separated	☐ Widowed	

Social Security Number

Contact Information of the Patient

Email	Home Phone Number	Cell Phone Number
Work Phone Number	Work Extension Number	
Responsible Party's Information		
Full name	Street address	City
State	Zip	Home Phone Number
Cell Phone Number	Work Phone Number	Work Extension Number
Social Security Number	Driving License Number	
Emergency Contact Information		
Full name	Phone number	
Primary Dental Insurance Details		
Do you have Dental Insurance?		
☐ Yes	☐ No	
Date of Insured	Dental Group Number	Dental Member ID
Name Of Insured	Relation To Patient	Insured SSN
Employer Name	Insured Person's Address	Insurance Company
Insurance Company Address	Insurance Company City	
Insurance Company State		
☐ Alabama	☐ Alaska	☐ Arizona
☐ Arkansas	☐ California	☐ Colorado
☐ Connecticut	☐ Delaware	☐ Florida
☐ Georgia	☐ Hawaii	☐ Idaho
☐ Illinois	☐ Indiana	☐ Iowa
☐ Kansas	☐ Kentucky	☐ Louisiana
☐ Maine	☐ Maryland	☐ Massachusetts
☐ Michigan	☐ Minnesota	☐ Mississippi
☐ Missouri	☐ Montana	☐ Nebraska

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| ☐ Nevada | ☐ New Hampshire | ☐ New Jersey |
| ☐ New Mexico | ☐ New York | ☐ North Carolina |
| ☐ North Dakota | ☐ Ohio | ☐ Oklahoma |
| ☐ Oregon | ☐ Pennsylvania | ☐ Rhode Island |
| ☐ South Carolina | ☐ South Dakota | ☐ Tennessee |
| ☐ Texas | ☐ Utah | ☐ Vermont |
| ☐ Virginia | ☐ Washington | ☐ West Virginia |
| ☐ Wisconsin | ☐ Wyoming | ☐ Puerto Rico |
| ☐ District of Columbia | ☐ US Virgin Islands | |

Insurance Company ZIP Code

Secondary Dental Insurance

Do you have Secondary Dental Insurance?

☐ Yes

☐ No

Date of Insured (copy)

Dental Group Number

Dental Member ID (copy)

Dental Member ID (copy)

Name of Insured

Relation to Patient

Insured SSN

Employer Name

Financial Agreement

Financial Agreement: I understand that I am responsible for payment of all dental services provided to me or my dependents. Insurance is a benefit provided by my insurance company and is not a guarantee of payment. I authorize Capital City Smiles to submit insurance claims on my behalf and understand that any remaining balance after insurance is my responsibility. Payment is due at the time of service unless other arrangements have been made in advance. By signing below, I acknowledge that I have read and agree to the financial policies of Capital City Smiles.

Communication Consent: I authorize Capital City Smiles to contact me by phone call, text message, and email regarding my appointments, treatment, billing, insurance, and other information related to my dental care.

Late Policy

Late Cancellation & No-Show Policy: We allow a 15-minute grace period for appointments. Arrivals more than 15 minutes late may need to be rescheduled. Cancellations or rescheduling with less than 24 hours' notice, as well as no-call/no-show appointments, are subject to a minimum \$75 fee. Appointments must be confirmed at least 48 hours in advance. Appointments that are not confirmed may be canceled by the office 48 hours prior to the scheduled appointment time.

HIPAA Agreement

HIPAA PRIVACY NOTICE: Capital City Smiles is committed to protecting your privacy and the confidentiality of your health information. We may use or share your information as permitted by HIPAA for treatment, payment, insurance, healthcare operations, scheduling, and communication regarding your care. You have the right to access your records, request corrections, request restrictions on certain disclosures, and request how we communicate with you. By signing below, you acknowledge that you have been provided with or offered a copy of our Notice of Privacy Practices.

Signature

Electronic signature

Date: