Saluda Smilemakers, Dr. Sam Wheeler

Patient Registration

First Name:_____Last Name:_____

Date of Birth: _____ SSN:_____

Mailing Address:_____

City_____ State _____ Zip Code_____

Home Phone: _____ Cell phone _____

RESPONSIBLE PARTY: (if other than patient)

First Name: _____ Last Name: _____

Date of Birth:_____SSN: _____

Mailing Address: _____

Home phone: _____ Cell phone: _____

Insurance Information:

Full name of Insured:_____

Relationship: _____

Insured Date of Birth:_____Insured SSN:_____

Employer: _____

PLEASE LET OUR INSURANCE COORDINATOR KNOW IF YOU HAVE SECONDARY INSURANCE

EMAIL ADDRESS:_____