Warrier Family Dentistry
Smita S Warrier DMD PLLC
16143 Lancaster Hwy, Suite 101
Charlotte NC - 28277

New Patient Registration

PATIENT INFORMATION

Name (Last, First, Middle):				☐ Male ☐ Female
Date of Birth:	SSN:	☐ Single ☐ Married ☐ Divorced Other:		
Street Address:		City:	State:	Zip:
Home Phone:	Cell Phone:	Office Phone:		
Email:		Fax:		
Spouse/Parent Name:		Relationship:		
Emergency Contact:		Relationship:		
Contact Cell Phone:				

INSURANCE INFORMATION

Insured Person's Name:	Date of Birth:	
Relationship to Patient:		SSN:
Insurance Name:	Group/Plan ID:	
Employer:	Phone:	

I acknowledge that the information provided above is true and correct to the best of my knowledge. I understand that it is my responsibility to provide a written communication to Dr. Smita Warrier or the office of any change in my information from that stated above.

Signature of Responsible Party Relationship to Patient Date

REFERRAL INFORMATION

How did you hear about us? ☐ Phone Book ☐ Marketing Flyer ☐ Internet ☐ Friend/Family ☐ Another Doctor ☐ Other _____

Name of person or office: _____