

PATIENT INFORMATION

First Name _____ Last Name _____ Middle Initial _____
Preferred Name _____
Home Address _____ City/State/Zip _____
Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____
Birth Date _____ Age _____ Sex: Male Female
Email _____ Soc.Sec# _____
Marital Status: Minor Single Married Divorced Separated Widowed
Your Employer _____ Occupation _____ City/State _____
May we contact you at work? Yes No
Spouse or parent/guardian's name _____
Whom may we thank for referring you to our dental office? _____
Person to contact in case of an emergency _____ Phone _____
Do you have dental insurance? _____ (if yes, continue)
Name of Insured _____ Relationship _____ Insured Employer _____

RESPONSIBLE PARTY

Name of person responsible for this account _____
Relationship to Patient: Self Spouse Parent Guardian
Home Address _____ City/State/Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Birth Date _____ Soc.Sec# _____
Email _____ May we contact them at work? : Yes No
Is this person currently a patient in our office? Yes No

We kindly ask that you provide 24 hours notice from scheduled appointment time if you need to cancel or reschedule your appointment. Failure to arrive for your appointment or not canceling 24 hours in advance may result in a \$50.00 broken appointment fee. _____ (Initial Here)

INSURANCE AUTHORIZATION – AGREEMENT TO PAY

I understand that although an estimate of insurance benefits will be provided to me based on previous submissions with my insurance company, the actual benefit my company may pay can occasionally be unpredictable and depends on my individual policy. I understand that I am ultimately responsible for all charges regardless of insurance coverage. I authorize my insurance company to make payments directly to Smile Solutions for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release to my insurance company all information necessary to secure payment.

SIGNATURE OF PATIENT, PARENT, OR GAURDIAN _____ DATE _____