Smile Solutions

Amy M. Scepaniak, DDS

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

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 pay Smile Solutions directly 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. I understand that payment is due when services are rendered.

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)*

***SIGNATURE OF PATIENT, PARENT, OR GAURDIAN_____DATE_____**