Smiles for Life DENTAL CARE

Patient Information

General Information

Today's Date _____ Patient Name (last, first, middle initial) _____

Preferred Name _____ Gender _____ Marital Status _____

Birthdate _____ SSN _____ Employer/School _____

Prefer contact by: ☐email ☐phone call ☐text

How did you hear about us? _____

Home Phone (____) _____ Street Address _____

City _____ State _____ Zip _____ Cell Phone (____) _____

Work Phone (____) _____ Email Address _____

Emergency Contact Information

IN CASE OF EMERGENCY, CONTACT (If possible, specify someone who does not live in your household.)

Name _____ Relationship _____

Phone (_____) _____ Alt. Phone (_____) _____

Dental Insurance Information

Do you have dental insurance? ☐ Yes ☐ No

If this is your own policy:

Is this through an employer? ☐ Yes ☐ No

Employer:_____

Insurance Co._____

ID #_____

Policy #_____

Group #_____

If you are on someone else's policy (parent, spouse, etc.):

Subscriber's Name_____

Relationship to Patient_____

Subscriber's Birthdate _____

Subscriber's SSN_____

Is this through an employer? ☐ Yes ☐ No

Insurance Co._____

Employer:_____

Policy #_____

Group #_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company[ies]) and assign directly to Smiles for Life all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**

The above-mentioned dentist may use my health care information and may disclose such information to the above-mentioned Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative