PERFECT SMILES
FAMILY DENTISTRY

Date: _____

Acct # _____

CONFIDENTIAL PATIENT INFORMATION

Please Print Clearly

I. Patient Information

Name:_____ Birthdate:_____ Gender:_____
Address:_____ City & State:_____ Zip Code:_____
Home Phone: (____)_____ Work Phone: (____)_____ E-mail: _____
Social Security: _____ Driver's License # _____
Employer's Name: _____ Phone Number: (_____)_____

II. Responsible Party (Primary Insurance Information)

Name _____ Relationship to Patient:_____
Social Security # ____-__-_____ Drivers Lic # _____ Birthdate:_____
Name of Employer:_____ Phone #:_____
Address:_____ City: _____ Zip Code:_____
Name of Insurance Company:_____Phone #:_____
Union/Local:_____ Group Number:_____
Occupation:_____ Date of Hire: _____

III. Second Insurance Information (Complete this section if patient is covered by another insurance company)

Name of the Insured :_____ Relationship to Patient:_____
Social Security: ____-__-_____ Drivers Lic #: _____ Birthdate: _____
Name of Employer: _____ Phone #: _____
Address:_____ City & State:_____ Zip Code: _____
Name of Insurance Company _____ Phone # (____)_____
Union/Local:_____Group #:_____
Occupation: _____ Date of Hire: _____

IV. Getting to Know You and Your Family

How did you hear about SmileCare?_____Last dental x-rays taken?_____
When was last dental visit? _____What treatment was performed?_____

Please list all immediate family members:

Name:	Relationship:	Birthdate	Date of last dental visit

V. Emergency Contact (Friend or relative not living with you)

Name : _____Telephone: (_____)_____

So we may bill your insurance directly, please sign.
I hereby authorize payment directly to SmileCare of the insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by my insurance. I authorize dental care and the release of any information necessary to bill my insurance carrier. In the event of default, I understand that I will be charged and I agree to pay all reasonable collection charges and/or attorney fees.

_____ (Signature of the Insured/Responsible Party)

FOR SIX MONTH RECALL ONLY
I hereby confirm there have been no changes to the above information.

Signature of the responsible party_____ Date_____