

## *Welcome to A Place To Smile*

Patient Name: \_\_\_\_\_ Male ☐ Female ☐ Date: \_\_\_\_-\_\_\_\_-\_\_\_\_

Patient Date of Birth \_\_\_\_\_ SSN: \_\_\_\_\_

If Child; Parent/Guardian \_\_\_\_\_ D/O/B/ \_\_\_\_\_ SSN \_\_\_\_\_

Residence Address \_\_\_\_\_

Mailing Address (If Different) \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Phone \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Favorite Local Restaurant: \_\_\_\_\_

For Insurance Purposes:

Name of Carrier \_\_\_\_\_ SSN and/or ID \_\_\_\_\_

Group Number \_\_\_\_\_ Are you covered by another plan? YES NO

If so, Name of Carrier \_\_\_\_\_ SSN and/or ID \_\_\_\_\_

Group Number \_\_\_\_\_

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_