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_____