PATIENT INFORMATION

* please fill out entire form*

DATE _________________ HOME # _________________________

PATIENT NAME ____ EMAIL ADDRESS _________________

Last Name First Name MI

IF PATIENT IS A MINOR, GIVE PARENT OR GUARDIANS NAME ____

SEX ___ Male ___ Female BIRTHDATE Month__________ Day____________ Year ____________

PATIENT SSN# ________________________ ___ Single ___ Married ___ Divorced ____ Widowed ____ Minor

MAILING ADDRESS _______________________________ CITY______________ STATE______ ZIP COPE_________

PHYSICAL ADDRESS _____________________________ CITY ______________ STATE _____ ZIP CODE ________

EMPLOYED BY__________________________________ OCCUPATION__________________ HOW LONG_________

BUSINESS ADDRESS ____ PHONE # ________________ Ext _______

WHO IS RESPONSIBLE FOR THIS ACCOUNT? ____

RELATION TO PATIENT? _____________________________ PATIENT DRIVERS LICENSE #__________________

SOMEONE TO NOTIFY IN CASE OF EMERGENCY (NOT LIVING WITH YOU)

____ PHONE # ___________________________

WHO MAY WE THANK FOR THIS REFERRAL ____

IMPORTMANT CONTACT NUMBERS

Please provide a telephone number we may call to confirm your appointments, or any other messages regarding treatment.

Home_________________________________ Work______________________________ Cell _______________________

DENTAL BENEFITS 1ST COVERAGE

Employer ____ Employee name______________________________________

Employee birthdate _______________________________________ SSN ____

Relation to patient __________________________ Insurance Co.________________________ Group #________________

Address ____ Phone # ______________________ ID# __________________

DENTAL BENEFITS 2ND COVERAGE

Employer ____ Employee name______________________________________

Employee birthdate ___________________________________ SSN ____

Relation to patient _____________________ Insurance Co.______________________ Group #______________________

Address ____ Phone # __________________ ID# ____________________

GENERAL CONSENT & RELEASE

I, the undersigned, understand that I am responsible for all charges whether or not paid by insurance, if applicable, I may or may not have DENTAL insurance and, if so, assign directly to Michael Smith, DDS, and all benefits, if any, otherwise payable to me for services render. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I understand that my dental care insurance carrier or payer of my dental benefit may pay less than the actual bill for services. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of any information concerning my health care, advice and treatment to another dentist, dental specialist, or physician.

______________ DATE

____ PATIENT SIGNATURE (If patient is a minor, parent or legal guardian sign)