



dentistry WITH A difference

Today's Date: \_\_\_\_\_

Patient Information

Name: \_\_\_\_\_
Last First Mi Mr Mrs Ms Dr

I prefer to be called: \_\_\_\_\_

Male Female Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

SS#: \_\_\_\_\_

Driver's License # \_\_\_\_\_

Home Address: \_\_\_\_\_
Apt/Condo #

City State Zip

Single Married Divorced Widowed Separated

Home Phone: ( ) Pager: ( )

Work Phone: ( ) Ext: \_\_\_\_\_

Cell Phone: ( )

Text Confirmation: Yes No

Email Confirm Confirmation: Yes No

How did you find out about our office? Circle all that apply.

Doctor/Dentist Friend Internet Mailer Other: \_\_\_\_\_

Employer

Employer's Address: \_\_\_\_\_

City State Zip

Length of employment: Occupation: \_\_\_\_\_

When are the best times to reach you? am pm

Whom may we Thank for referring you?: \_\_\_\_\_

Person Responsible for Account/Spouse

Name: Birthdate: \_\_\_/\_\_\_/\_\_\_

Employer: \_\_\_\_\_

Driver's License #: \_\_\_\_\_

Work Phone:( ) Home Phone:( )

Relationship: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Primary Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone: ( )

Policy # \_\_\_\_\_

Group Number (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relationship: Birthdate: \_\_\_/\_\_\_/\_\_\_

Insured's SS #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

Secondary Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone: ( )

Group Number (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relationship: Birthdate: \_\_\_/\_\_\_/\_\_\_

Insured's SS #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

In the event of an emergency, whom should we contact?

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Work Phone: ( )

Home Phone: ( )

Table with 5 columns: Patient Name, Date of Birth, Sex, Age, Social Security Number. Contains 6 rows for patient data entry.

PATIENT INFORMATION

Please sign back.

**PAYMENT IS DUE IN FULL AT TIME OF SERVICE, INCLUDING ANY DENTAL INSURANCE DEDUCTIBLE AND/OR ESTIMATED PORTION UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.**

**Authorization and Release**

I understand that if I have insurance, Stafford Smiles will prepare and submit my dental claim as a service to me. I also accept full financial responsibility for all charges whether or not they are covered by insurance.

I hereby authorize payment directly to Stafford Smiles of the group insurance benefits otherwise payable to me. I also authorize release of any information including the diagnosis and records of treatment or examination rendered to my insurance company. If it becomes necessary to effect collections of any amount owed on this, or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney fees.

Returned checks and balances older than 60 days may be subject to additional collection fees and interest charges of 1.5% per month, or 18% annually. These additional fees will be applied to the unpaid balance at the end of the month.

**Name** (Please print): \_\_\_\_\_

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