



Thank you for choosing Smiles For Life Dentistry! To help us meet all your dental healthcare needs, please fill out the five boxes completely. Please use **black ink**

Patient Information

Name _____ Date _____

Preferred Name: _____

Address _____

city state zip

Birthdate: _____ Gender: F M Age _____

Marital Status: _____

Employer _____

Occupation _____

How did you hear of us? _____

Phone Numbers

Home Phone _____ Work _____

Cell _____

Spouse's Work _____

What is the best way to reach you? _____

Time of day? _____

Email: _____

EMERGENCY CONTACT

Name _____

Relationship _____

Phone #'s _____

Dental Insurance

Primary Dental Carrier

Subscriber Name _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Ins. Claims Address: _____ Subscribers Relationship to Patient _____

Secondary Dental Carrier

Subscriber Name _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Ins. Claims Address: _____ Subscribers Relationship to Patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment.

Signature _____ Date _____