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 ______

Patient SS#: _________-_________-_________

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 ______________________________ Subscriber ID# ________________________ DOB ________________

Employer ____________________________________ Insurance Co. ____

Insurance Co. Phone # ________________________ Group # ____

Ins. Claims Address: ___________________________ Subscribers Relationship to Patient ___________________________

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Secondary Dental Carrier

Subscriber Name ______________________________ Subscriber ID# ________________________ DOB ________________

Employer ____________________________________ Insurance Co. ____

Insurance Co. Phone # ________________________ Group # ____

Ins. Claims Address: _________________________ Subscribers Relationship to Patient ___________________________

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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** ______________________