Personal Information

Prefix:__________ Patient First Name:_________________________________ Middle:_______________________
Last:________________________ Suffix:________ SSN:____________________________ DOB:________________
Address:____ Apt. #:________________
City/State:____ Zip Code:_____________________
Home #:____________________________________ Cell #:____________________________________
Work #:____________________________________ Other #:__________________________________
Email:____

Appointment confirmations will be automatically sent to your e-mail unless you indicate otherwise.

Drivers License #:__________________________________ State:___________ Marital Status:_________________
Employer:____ Occupation:_______________________________________
Student? **Yes/No** Name of School:_____________________________________ Full or Part Time:________________
Grade:____________ Estimated Graduation Date:_______________________________
Emergency Contact Name:____ Phone #:_______________________
Relationship to Patient:____
How did you hear about our practice?____

Insurance Information

______By initialing here, I hereby authorize Signature Smile Family Dentistry to contact my insurance company for any necessary information.

Please present your card to be photocopied

Do you have dental insurance? **Yes/No**
Primary Insurance Co. Name:____ Phone #:_______________________
Subscriber Name:___________________________________ Subscriber Employer:______________________________
Subscriber SSN:_____________________________________ Subscriber DOB:__________________________________
Member ID#:_______________________________________ Group #:____

Do you have secondary dental insurance? Yes/No
Secondary Insurance Co. Name:____ Phone #:_______________________
Subscriber Name:___________________________________ Subscriber Employer:______________________________
Subscriber SSN:_____________________________________ Subscriber DOB:__________________________________
Member ID#:_______________________________________ Group #:____

Treatment, Cancellation, & Payment Policy

I, the patient/patient's guardian, authorize Signature Smile Family Dentistry to perform treatments including, but not limited to prophylaxis (cleaning), taking x-rays and photographs, administering anesthetics and/or medications, restorations (fillings), removing teeth (extractions), endodontic treatment (root canals), and other procedures as deemed necessary by the staff for my/my child's proper care. I agree to update the office of any changes to my personal information in a timely manner.

Patient/Patient's Guardian's Signature:____ Date:____________________

Patient/Patient's Guardian's Signature:____ Date:____________________