SMILES DENTAL | FAMILY DENTISTRY

PATIENT CONTACT & INSURANCE INFO

Patients name (Print): _____ **DOB:** _____

If patient is a child parent/guardian's name: _____

Address: _____

Apt#: _____City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Business phone: _____ Email: _____

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Name of spouse: _____

***Emergency contact:** _____ **Phone#:** _____

Primary insurance:

Subscriber Name: _____ Subscriber DOB: _____

Subscriber ID & Social Security #: _____ & _____

Name of employer: _____Group #: _____

Employer address: _____

Dental Insurance Company: _____ Phone #: _____

If any secondary dental insurance:

Subscriber Name: _____ Subscriber DOB: _____

Subscriber ID & Social Security #: _____ & _____

Name of employer: _____Group #: _____

Employer address: _____

Dental Insurance Company: _____ Phone #: _____

Patient's/Guardian Signature: _____ Date: _____