SmileStudio

Last Name: _____ First Name: _____M.I: _____

Address: _____

Home Phone: (____)_____-_____ Cell Phone: (____) ____-_____ Work Phone: (____)_____-_____

DOB: ___/___/_____ Sex: M/F SSN: _____- _____-_____ Marital Status: _____

Employer:_____ Occupation:_____

Email Address: _____ Referred By:_____

Preferred Way of Contact : Phone Text Email

Emergency Contact:_____ Telephone Number: _____

Insurance

Primary Insurance Company: _____

Identification Number: _____ Group Number: _____

Primary Policy Holder: _____ DOB: ____/____/____ SSN:_____-_____-_____

Secondary Insurance Company: _____

Identification Number: _____ Group Number:_____

Primary Policy Holder: _____ DOB: ____/____/____ SSN: _____-_____-_____

Responsible For Payment

Name: _____ DOB:____/_____/___ _ SSN: _____-_____-_____

Address: _____

Primary Contact Number: (_____)_____-_____ Secondary Contact Number: (__ ____)_____-_____

Employer:_____ Occupation:_____

Relationship to the Patient: _____

I authorize payment directly to Smile Studio for dental services rendered. I understand my responsibility as a patient at Smile Studio. By signing this is acknowledge all information provided above is correct to the best of my knowledge.

Signature (Patient/Guardian): _____