SMILEY DENTAL GROUP

SMILEY · HOLOWICKI
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New Patient Information

Name (Last, First, Middle):_____Title: _____ Preferred Name: _____
Home Address: _____ City/State/Zip: _____
DOB: ____/____/____ Marital Status: _____ Sex: _____ SS No: _____-_____-_____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-Mail: _____ Employer:_____ Occupation: _____
If patient is minor- Father's Name: _____ Mother's Name: _____
Student: ☐ Yes ☐ No Where: _____ Full-Time or Part-Time: _____
Have you or any of your family members been patients in this practice? ☐ Yes ☐ No
If yes, what is the family member's name? _____

Primary Dental Insurance Coverage

Name of person who carries insurance: _____ Relationship to Patient _____
Address: _____ City/State/Zip: _____
Employer: _____ SS No: _____-_____-_____
Employer Address: _____ DOB: _____/_____/_____
Insurance Co: _____ Ins. Co. Phone: _____
Ins. Co. Address:_____ City/State/Zip: _____
Group No: _____

Secondary Dental Insurance Coverage

Name of person who carries insurance: _____ Relationship to Patient _____
Address: _____ City/State/Zip: _____
Employer: _____ SS No: _____-_____-_____
Employer Address: _____ DOB: _____/_____/_____
Insurance Co: _____ Ins. Co. Phone: _____
Ins. Co. Address:_____ City/State/Zip: _____
Group No: _____

I, the undersigned, certify that I (or my dependents) have dental insurance coverage and that I assign directly to the dentist all insurance benefits for services rendered, otherwise payable to me. I understand that I am financially responsible for all charges, whether or not paid by insurance companies. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature in all insurance submissions.

Responsible Party Signature: _____ Date: _____