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: ______________________________ Subscriber ID 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: ______________________________ Subscriber ID 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: _______________