WELCOME
TO
SMILE DESIGN DENTISTRY

PATIENT'S NAME _____

ADDRESS _____

CITY _____ ***STATE*** _____ ***ZIP*** _____

BIRTHDAY _____ ***MARITAL STATUS*** _____ ***EMAIL***_____
(mo/day/year)
MAY WE YOU SEND APPOINTMENT REMINDERS VIA EMAIL OR TEXT MESSAGE SERVICE- YES_____NO_____
HOME PHONE ( )_____ WORK # ( )_____ CELL # ( )_____
HOW LONG SINCE YOUR LAST DENTAL EXAMINATION_____
WHOM IS RESPONSIBLE FOR THIS ACCOUNT _____
ADDRESS OF PERSON IF DIFFERENT FROM PATIENT _____
EMPLOYED AT: _____SPOUSE EMPLOYED AT:_____
REFERRED BY: _____

PRIMARY DENTAL INSURANCE INFORMATION:

POLICY HOLDER NAME _____ DATE OF BIRTH _____
NAME OF INSURANCE CARRIER _____
ADDRESS OF INSURANCE COMPANY _____
PHONE NUMBER _____ SUBSCRIBER NUMBER _____
GROUP NUMBER _____ SOCIAL SECURITY NUMBER _____
EMPLOYER NAME _____ POLICY HOLDER DATE OF BIRTH _____

*****SECONDARY INSURNACE INFORMATION***

POLICY HOLDER NAME _____ DATE OF BIRTH _____
NAME OF INSURANCE CARRIER _____
ADDRESS OF INSURANCE COMPANY _____
PHONE NUMBER _____ SUBSCRIBER NUMBER _____
GROUP NUMBER _____ SOCIAL SECURITY NUMBER _____
EMPLOYER NAME _____ POLICY HOLDER DATE OF BIRTH _____

SIGNATURE _____ DATE _____