Welcome! Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date_____Soc. Sec. #_____Birthdate_____

Name_____Home Phone_____

Address_____Cell Phone_____

City_____State_____Zip_____Email_____

Sex:____M____F ____Minor____Single____Married____Divorced____

Employer_____Business Phone_____

Who should we thank for referring you?_____

In case of emergency, who should we contact?_____Phone_____

Person Responsible for Account_____

Primary Dental Insurance Information

Insured Name_____Relationship to Patient_____

Birthdate_____Soc. Sec. #_____ Home Phone_____

Address_____City_____State_____Zip_____

Employer_____Work Phone_____

Insurance Company_____Subscriber ID_____Group #_____

Additional (Secondary) Dental Insurance

Insured Name_____Relationship to Patient_____

Birthdate_____Soc. Sec. #_____ Home Phone_____

Address_____City_____State_____Zip_____

Employer_____Work Phone_____

Insurance Company_____Subscriber ID_____Group #_____

I hereby authorize payment directly to Healthy Smile for all insurance benefits. I understand I am financially responsible for all charges whether or not paid by insurance, and for all service rendered on my behalf or my dependents.
I authorize Healthy Smile and any provider of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____Date_____

Signature of Responsible Party