ABSOLUTE SMILE
Family Dentistry

Date:_____

# PATIENT INFORMATION

Full Name: | Preferred Name: | Date of Birth:

Phone Number: | Email: | Gender:

Address: | City: | State/Zip Code:

Marital Status: | Occupation: | Employer:

Previous Dentist: | How did you hear about our office?

## RESPONSIBLE PARTY

*This section only needs to be completed if the responsible party is anyone other than the patient*

Full Name: | SSN: | Date of Birth:

Address: | City: | State/Zip Code:

Emergency Contact Name: _____

Emergency Contact Number: _____

Are you interested in straightening your teeth? ☐ Yes ☐ No

Are you interested in facial aesthetic services? ☐ Yes ☐ No

*FOR YOUR CONVENIENCE, OUR OFFICE CAN COMMUNICATE WITH YOU BY EMAIL AND TEXT MESSAGE.*

I authorize this office to contact me via text message. ☐ Yes ☐ No

I authorize this office to contact me via email. ☐ Yes ☐ No

## INSURANCE

### Primary:

Insurance Company:_____

Policy Holder Name:_____

Relationship to Patient:_____

Policy Holder Date of Birth:_____

Policy Holder SSN:_____

Member ID:_____

Employer:_____

Group Name:_____

Group Number:_____

### Secondary:

Insurance Company:_____

Policy Holder Name:_____

Relationship to Patient:_____

Policy Holder Date of Birth:_____

Policy Holder SSN:_____

Member ID:_____

Employer:_____

Group Name:_____

Group Number:_____

I CERTIFY THAT I, AND/OR MY DEPENDENT(S), HAVE INSURANCE COVERAGE WITH THE ABOVE-NAMED INSURANCE COMPANY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. ABSOLUTE SMILE MAY USE MY HEALTHCARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR BENEFITS PAYABLE TO RELATED SERVICES. THIS CONSENT WILL STAY IN EFFECT AS LONG AS I AM A PATIENT WITH ABSOLUTE SMILE

Name:_____ Signature:_____

Relationship to Patient:_____